Emergency Medical Services/Trauma Committee

Mar 25, 2015 at 10:30 AM - 02:30 PM

California Hospital Association

1215 K Street, Suite 800

Sacramento, California 95814

Conference Call Option:

(800) 882-3610 Access Code: 1953936#

Meeting Book - EMS/Trauma Committee Meeting

AGENDA

Meeting Facilitator: BJ Bartleson

10:30 **1. CALL TO ORDER/INTRODUCTIONS** MAAS

- I. Membership
  - i. Roster
    - a. EMST Roster 2015 - Page 5
  - ii. Member Updates
    - a. Memo - Member Updates - Page 8
    - b. CV's/Bio's of Member Candidates and Alternates
      - Alison Kerr - Page 9
      - Chris Walker - Page 10
      - Jennifer Wobig - Page 15
      - Ron Smith - Page 18
      - Larry Stock - Page 19
  - iii. Member Map
    - a. Committee Representation - Page 24
  - iv. Member Type
    - a. CHA Member/ED Breakdown - Page 25
- II. Committee Guidelines
  - i. Guidelines - Page 26
- III. EMS/T Workgroups
  - i. EMS/T Proposed Workgroups - Page 30

10:55 **2. MINUTES** *Recommend: Approval* MAAS

September 10, 2014 and December 7, 2014

- I. Minutes Draft EMS/T 091014 - Page 31
- II. Minutes Draft EMS/T 120714 - Page 36

3. OLD BUSINESS

11:00 I. ED Overcrowding ROGERS

Time	Item	Presenter
	i. ED Overcrowding - Page 39	
11:15	II. Community Paramedicine Partnership	PEARSON
	i. Paramedicine - Page 57	
11:30	III. Wall Time/EMSA Final	BARTLESON
	i. Wall Time Collaborative Meeting Final - Page 65	
	4. NEW BUSINESS	
11:35	I. AHRQ	FAIR
	i. AHRQIX Dec 7 Webinar - Page 136	
11:50	II. Ebola	HUMMEL
12:00	III. Lunch	
12:30	IV. Proposed Legislation	BARTLESON
	i. EMST Bill Review 0315 - Page 152	
	ii. AB 503 - Page 155	
	iii. AB 503 Fact Sheet - Page 157	
	iv. AB 579 - Page 158	
12:50	V. Proposed Regulations	BARTLESON
	i. EMSA Proposed Regulations Information - Page 165	
	ii. EMSA Ephinephrine Regulations Information - Page 179	
1:15	VI. PES AND 5150	KRUCKENBERG
	i. PES white paper with map - Page 184	
	ii. AB 1300 - Page 191	
	iii. FACT SHEET ON AB 1300 - Page 232	
	iv. LPS flowcharts - Page 233	
1:30	VII. SBAR	BARTLESON
	i. SBAR - Page 235	
1:40	VIII. Goals for 2015	BARTLESON
2:00	**5. DECEMBER 2015 CENTER FOR BEHAVIORAL HEALTH AND EMS/TRAUMA JOINT CONFERENCE**	BARTLESON
	I. SAVE THE DATE - Page 237	
2:15	**6. ROUNDTABLE DISCUSSION**	ALL

2:25	**7. INFORMATION ONLY**	MAAS
	I. Next Meeting June 24, 2015 - Sacramento	
	i. 2015 EMS/T Meeting Schedule - Page 238	
2:30	**8. ADJOURNMENT**	MAAS

EMS/TRAUMA COMMITTEE
2015 MEMBER ROSTER

CHAIR

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Last revised 3/20/15

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Last revised 3/20/15

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DATE: March 25, 2015

TO: EMS/Trauma Committee Members

FROM: Marla Bartle, CHA Staff

SUBJECT: Member Updates

NEW MEMBERS

The following member begins her tenure with the EMS/T Committee, effective March 25, 2015.

Susan Thompson, RN, MSN, ACNP-BC
Trauma and Disaster Programs Manager, Huntington Memorial Hospital

MEMBER RESIGNATIONS

Rhonda Filipp no longer works at CHPSO. She thanks the committee for the chance to have worked with you.

Stacy Vincent resigned her position as ED Nurse Manager at Enloe and asked to be removed from the committee.

Janet Rimicci has left Stanford for another position in Southern CA and thanks the committee for the opportunity to participate.

Andrew Greene, Darin Huard and Sharon Rudnick are no longer at their respective positions at member hospitals.

MEMBER CANDIDATES

Alison Kerr – Replaced Janet Rimicci at Stanford and has expressed interest in joining the committee

Chris Walker – Director of Emergency Services at Sharp Memorial Hospital, San Diego

Jennifer Wobig – Trauma Program Manager at Santa Barbara Cottage Hospital (referred by Kim Murphy)

MEMBER ALTERNATES

Eric Morikawa requested that *Ron Smith* (CDPH Licensing & Certification) be his alternate

Dr. Vivian Reyes requested that *Dr. Lawrence Stock* be her alternate for Cal ACEP representation

MEMBER LEADERSHIP

CHA is reaching out to its hospital members to fill the Chair position on the EMS/Trauma Committee. If you, or you know of someone, who is interested in this position, please contact BJ at your earliest convenience.

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

Alison Marie Kerr RN, MSN

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Stanford, CA 94305
Work: (650) 498-6180
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Alison Marie Kerr joined Stanford University Medical Center, September 1991 as a clinical nurse, and has risen through the ranks of hospital leadership to her current role as Vice President of the Neuroscience Service Line, Psychiatry and Behavioral Science Service Line, Emergency Department, Trauma and the Office of Emergency Management reporting to the Chief Operating Officer. Previous roles at Stanford include Director of Business Development for the Neuroscience Service Line, which involved co-leading a 5 year Neuroscience Strategic plan and responsibility for business development, programmatic growth, and marketing of Neuroscience service line, and other managerial and operational leadership roles, managing over 100 FTE's.

In her current role as Vice President, Alison is responsible for the management and design of the Neuroscience & Psychiatry Service Lines across the continuum of outpatient to inpatient services with the overall objective of improving throughput, operational and financial efficiencies and delivering a superior patient experience. Additional areas of responsibility include the Emergency Department, Trauma and the Office of Emergency Management. She is also in charge of the building and operationalization of an integrated Neuroscience Outpatient Center; a 5 story, 92K square foot building including a Radiology platform, Infusion Center, Neuro rehabilitation and integrated clinical research space. This 80 million dollar building is set to be open Fall 2015.

As a member of the Emergency Management Steering Committee, Alison is the Planning Chief for the Stanford Hospital Incident Command Center. Other committee memberships include Clinical Space and Transition Cabinet responsible for campus wide clinical space decisions and recommendations to the CEO including oversight, and building of the new 1.8 billion dollar new Stanford Hospital facility - set to be completed in 2018.

Partnering with preeminent School of Medicine Neuroscience and Psychiatry Faculty, the partnership, and collaboration of innovation, science and clinical operations have flourished at Stanford University Medical Center under the executive direction of Ms. Kerr.

Christopher Walker, MS, RN, NP, CNS, CCRN, CEN

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7955 Calle Posada, Carlsbad, CA 92009
walkssd@gmail.com

Professional Profile

Highly reliable nursing operations director with demonstrated ability to lead organizational change at the highest level with proven results in efficiency and quality. Led division to top-decile performance in patient satisfaction, physician satisfaction and employee engagement through continuous performance improvement, professional development, and collaborative partnerships. Grown patient volume, increased outpatient market share and contributions to the bottom line of the hospital.

Personal Achievements

- Expert change agent and Lean leader
- Proficient national speaker on nursing leadership and clinical practice
- Experienced lobbyist for the advancement of the nursing profession
- Professional nursing organization leadership (SDAACN)

Organizational Achievements

- ENA Lantern Award 2014
- Magnet Recognition 2008/2012
- Planetree Designation 2012
- Baldrige Award 2007
- Joint Commission Accreditation (Hospital, Stroke, LVAD)

Professional Experience

Sharp Memorial Hospital, San Diego, CA
2000 - Current
Director of Emergency Services
(July 2010 – Current)

Achievements:

- Lean transformation to improve efficiency and patient satisfaction
  - Reduced admission times by 75%
  - Reduce total ED length of stay by 1.8 hours
  - ED Patient Satisfaction scores from 40th percentile to eight consecutive quarters above the 90th percentile rank
- Reduced registry utilization by $500K
- 4 Consecutive years MD satisfaction and partnership > 95th percentile
- Employee engagement at top-decile, Tier I Performance
- Increased net-revenue for 4 consecutive years
- Established Certified Emergency Nurse (CEN) program

Responsibilities:

- $28 M Budget, 300 FTEs across 5 departments/programs
- Oversight of cost-effective, high quality patient care delivery in all areas
- Set vision for areas of responsibility aligned with nursing and organizational strategic plan
- Magnet and Planetree planning and leadership to assure designation
- Participation in several organizational change projects at the system, and entity level
- Leading professional development, mentorship, and quality improvements at all levels of the organization

Nursing Manager
Medical Intensive Care Unit/ Rapid Response & Central Telemetry (March 2008 – July 2010)

Achievements:

- Execution of hospital move into Stephen Birch Healthcare Center
- Hired 45 new nurse to staff 24 bed ICU, with 95% two-year retention rate
- Established Certified Critical-care Nurse (CCRN) program

Responsibilities:

- $10M budget, 100 FTEs across 2 departments
- Direct oversight of patient care services, quality improvement, and professional development of staff

Clinical Nurse Specialist
Surgical Intensive Care Unit/PACU (June 2006 – March 2008)

Achievements:

- Successful Magnet designation leadership
- Pioneered several nurse-led protocols to improve the quality of care for critically ill patients

Responsibilities:

- Leading evidence-based practice and performance improvement
- Manage non-productive hour utilization for education and training
- Advancing the profession of nursing as a leader, scientist, and expert clinician

Clinical RN/Advanced Clinician
Surgical Intensive Care Unit (March 2000 – June 2006)

Saint Louis University Hospital, St. Louis, MO
1999 - 2000
Clinical Nurse
Neurosurgical/Abdominal Transplant Intensive Care Unit

VA Medical Center, Jefferson Barracks, St. Louis, MO
1997 - 1999
Clinical Nurse
Acute Spinal Cord Injury Rehabilitation

Education

San Diego State University, San Diego, CA
Master of Science in Nursing – Adult Nurse Practitioner/Clinical Nurse Specialist
2006

Saint Louis University, St. Louis, MO
Bachelor of Science in Nursing
1997

Licensures/Certifications

Registered Nurse with California since 2000 and in Missouri from 1997-2000

Clinical Nurse Specialist Certificate with State of California since 2006

Nurse Practitioner Certificate with State of California since 2006

Certified Critical Care Nurse (CCRN) 2008, 2011, 2014

Certified Emergency Nurse (CEN) 2012

Trauma Nurse Core Course (TNCC) Provider/Instructor Certification since 2006

Publications

Bellezzo JM, Shinar Z, Davis DP, Jaski BE, Chillcott S, Stahovich M, Walker C, Baradarian S, Dembitsky W. Emergency Physician-Initiated Extracorporeal Cardiopulmonary Resuscitation. *Resuscitation*. 2012; 83 (8): 966-970

Priorities in Critical Care Nursing: Diagnosis and Management, 6th edition, 2012
Chapter Contributor: Shock, Sepsis, and Multiple Organ Dysfunction Syndrome (Mosby-Elsevier)

Walker, Christopher. Redefining emergency department care from the patient's perspective. *Planetalk: Official Newsletter of the Planetree Organization*. June 2011.

Critical Care Nursing: Diagnosis and Management, 6th edition, 2010
Chapter Contributor: Systemic Inflammatory Response Syndrome and Multiple Organ Dysfunction Syndrome (Mosby-Elsevier)

Professional Memberships

American Hospital Association/ American Organization of Nurse Executives 2013

American Association of Critical Care Nurses
- National/San Diego Chapter Member 2002 – current
- San Diego Chapter Board Member 2006 – 2010
  Publications Chair 2006 – 2007
  President-elect/President 2008 – 2009
  Past-President/Advisor 2010

Emergency Nursing Association (ENA)
- National/State/Local member 2010 – current

Presentations

Eastern Association for Surgery of Trauma 28th Scientific Assembly, Orlando 01/2015
Breaking down cultural walls preventing effective ED and hospital throughput

Piedmont Healthcare – Emergency Services Collaborative, Atlanta 10/2014
Breaking down cultural walls preventing effective ED and hospital throughput

Patient Flow and Emergency Management Summit, Chicago 06/2014
Innovative patient care techniques and throughput designs in the ED

HealthLeaders Media Live from Sharp Memorial Hospital (Webinar) 08/2013
Emergency Department Throughput Redesign

Planetree Live – International Conference, Palm Springs 10/2012
Patient-centered Lean demonstration

Planetree Annual International Conference Presentation, Nashville 10/2011
Be a lean machine: Creating a wait-less, leaner, patient-centered emergency experience

ANCC: National Magnet Conference Virtual Poster Presentations 10/2011
Applying lean methodologies to healthcare culture to improve safety, satisfaction, and throughput

AACN National Teaching Institute Exposition (Washington D.C) 5/2010
Sponsored by Philips Healthcare
Hypothermia: From theory to evidenced-based practice

AACN: National Teaching Institute (Washington D.C) Poster Presentations 5/2010
A Tale of Three Cultures Educational Symposium: A unique collaboration between San Diego Nursing Organizations

SDAACN Contemporary Topics Conference Presentation, San Diego 5/2009
Using an innovative approach for early intervention to improve outcomes in the acute care setting: RRT and high risk patient identification

Academy of Medical-Surgical Nurses, San Diego 5/2009
A paradigm shift: Using an innovative approach for early intervention to improve outcomes in the acute care setting

Tale of Three Cultures Conference 4/2009
Expert Panel Moderator: An impetus for change: The impact of new regulations on patient outcomes

AACN: National Teaching Institute Poster Presentations, Chicago 5/2008
Implementing a best practice model for traumatic brain injury management (poster)

Using guidelines to increase appropriate utilization of therapeutic beds for patients with pulmonary alterations (poster)

7th Annual ACNL Innovations Conference, San Diego 11/2007

Implementing a rapid response team: An evidence-based approach (podium)

Implementing a Best Practice Model for Traumatic Brain Injury Management (poster)

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Jennifer D. Wobig RN, BSN

Professional experience

2011-Current Santa Barbara Cottage Hospital Santa Barbara, CA

Trauma Program Manager

- Responsible for the organization of services and systems for multidisciplinary approach to providing care in injured patients
- Provide educational, clinical, research and administrative activities within the program
- Coordinate with physicians, nurses and other hospital staff to evaluate and address trauma patient care issues
- Assess the need for policies, procedures, protocols, supplies and equipment related to the care of trauma patients
- Coordinator for TNCC and ATLS Courses
- Assist the Trauma Medical Director and hospital administration in the development, implementation, and evaluation of a quality plan focused on patient outcomes.

2009-2011 Providence Holy Cross Medical Center Mission Hills, CA

Director, Trauma Services

- Achieved American College of Surgeons Trauma Center Re-Verification in 2011
- Responsible for leadership and strategic direction of the Trauma Program
- Develop budget for the service and allocate funds within budget to accomplish objectives
- Direct educational, clinical, research, administrative and outreach activities within the Trauma Program
- Responsible for process and performance improvement activities as it relates to nursing and ancillary and physician personnel
- Support a collaborative role for the physicians (trauma surgeons, specialists, emergency physicians) and other health care professionals involved in emergency and trauma patient management

- Provide support for the trauma team and maintain a strong component of trauma patient advocacy
- Coordinate trauma care management across the continuum of care

2005-2009 California Hospital Medical Center Los Angeles, CA

Trauma Program Director

- Achieved American College of Surgeons Trauma Center Verification in 2005
- and Re-Verification in 2008
- Organized services and systems for a multidisciplinary approach throughout the continuum of trauma care
- Responsible for process and performance improvement for nursing, ancillary and physician personnel
- Directed policy formulation and ongoing review of departmental and hospital-wide policies and protocols that relate to the trauma program
- Coordinated with clinical departments on development of guidelines and protocols for the trauma patient
- Provided trauma related education to physician, nursing and ancillary staff
- Coordinated hospital and community injury prevention programs
- Responsible for the financial performance of the Trauma Program

2004 – 2005 California Hospital Medical Center Los Angeles, CA

Clinical Supervisor – Emergency Department

- Charge Nurse for 21 bed Emergency Department and Level II Trauma Center
- Performed yearly performance evaluations, scheduling, timekeeping, and chart auditing

2002 – 2004 American Mobile Healthcare San Diego, CA

Travel Nurse

- California Hospital Medical Center – Emergency Department
- University of Maryland Medical Center – Emergency Department

2000 – 2002 Riverside Medical Center Columbus, OH

Staff Nurse – Mother/Infant

- Performed nursing care to post-partum mothers and newborns

- Triaged normal newborns

Staff Nurse- Emergency Department

- Performed nursing care in a 50 bed Emergency Department and Level II Trauma Center
- Relief Charge Nurse

1999 – 2000 Barnes-Jewish Hospital St. Louis, MO

Staff Nurse – Medical Hematology/Oncology

- Performed nursing care to bone marrow transplant and neutropenic patients
- Administered chemotherapy
- Relief Charge Nurse

Education

1995 - 1999 Capital University Columbus, OH

Bachelors of Science in Nursing

1991 – 1995 Lexington High School Lexington, OH

High School Diploma

Professional memberships

Emergency Nurses Association (2003) Society of Trauma Nurses (2005) American Trauma Society (2005) Trauma Managers Association of California (2007) Trauma Center Association of America (2010), South West Regional Trauma Coordinating Committee (2011)

Certifications

ACLS, PALS, BCLS, TNCC Instructor, TNCC Course Director, ATCN Instructor, ATLS Course Coordinator

Ron Smith

Emergency Management
Disaster Coordinator

Licensing and Certification,
California Department of Public Health

Ron Smith was appointed as the California Department of Public Health Licensing and Certification's (L&C) Disaster Coordinator for Emergency Preparedness and Disaster Response in September, 2008. In this position, he provides guidance to L&C's 18 District Offices and some 700 staff, and assistance to 7,500 healthcare facilities to effectively prepare for, respond to, and recover from emergency events across the state. Additionally Ron is assigned as L&C's CAHAN Coordinator, the Aerosol Transmitted Disease Liaison, and Emergency Duty Officer Coordinator. He also assists in writing All Facility Letters (AFL) and Policy and Procedures as they relate to L&C emergency preparedness and disaster response matters.

Ron has more than 30 years of experience in healthcare, with a background in emergency medicine, in nursing and emergency disaster management. He has been licensed as a nurse for 25 years; he also has EMT1A and Pharmacy Technician licenses, hearing conservationist and hazardous materials certified. He has worked in Intensive Care Units and Emergency Departments. He also has a back ground as a Medical Corpsman in the US Navy/Marines, Peace Officer/SWAT, and is a Terrorism Liaison Officer.

With experience and training in Emergency Management, Incident Command Systems, Emergency Operation Centers, and consistently an active participant in the annual State of California's Golden Guardian and other important disaster drills throughout the years for the State of California, Ron is able to contribute his extensive experience, training and knowledge to promote the EMS Trauma Committee.

Lawrence Michael Stock, MD, FACEP

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Education

1988 - 1991	Emergency Medicine Residency Department of Emergency Medicine Harbor / UCLA Medical Center
1983 - 1988	M.D. Degree UCLA School of Medicine
1980 - 1984	B.S. with Honors UC Riverside / UCLA Biomedical Sciences Program

Licenses

Diplomate of the American Board of Emergency Medicine
California State Medical License # G067852
DEA License # BS 2289189

Appointments

2011- Present	2012-2015: Officer and Executive Committee Member 2015: Vice President 2011-2012: Member at Large Board of Directors, California Chapter, American College of Emergency Physicians
2007 - 2008	Member at Large, Medical Executive Committee Antelope Valley Hospital
2000 - Present	Senior Examiner American Board of Emergency Medicine
2007 - Present	Clinical Professor UCLA School of Medicine
2001 - 2007	Associate Clinical Professor UCLA School of Medicine
1995 - 2001	Assistant Clinical Professor UCLA School of Medicine
1993 - 1995	Clinical Instructor UCLA School of Medicine

TEACHING

2005 - Present	Attending Physician UCLA Olive View Emergency Medicine Residency Program Department of Emergency Medicine Antelope Valley Hospital
1999 - 2004	Attending Physician Umma Free Clinic UCLA/King Drew School of Medicine
1998 - 2000	Small Group Tutor Doctoring 1 UCLA School of Medicine
1991 - Present (7/1/91)	Attending Physician / Clinical Faculty Member Department of Emergency Medicine Harbor / UCLA Medical Center

PRACTICE

1996 - Present (5/15/96)	Vice Chairman (2009-Present) Medical Director (2014-Present) Department of Emergency Medicine Antelope Valley Hospital Lancaster, California
1994 - 1999 (11/1/94 to 12/31/99)	Emergency Physician Saint John's Health Center Santa Monica, California
1993 - 1995	Emergency Physician San Pedro Peninsula Hospital San Pedro, California
1991 - 1993	Emergency Physician Midway Hospital Medical Center Valley Presbyterian Hospital Simi Valley Hospital

International

2015	Ebola Treament Unit Physician and World Health Organization National Training of Master Trainers on Triage and Emergency Care Bong, Kakata, and Monrovia, Liberia *International Medical Corps*
2013	Disaster Assistance Response Team/ Typhoon Yolanda

	Panay Island, Philippines *Access Aid International*
2011	Physician Volunteer Baptist Medical Centre Nalerigu, Ghana
2005	Medical Director/Earthquake Relief Kashmir/Pakistan *Access Aid International*
2004 -2005	Physician Volunteer/Tsunami Relief Sri Lanka *Global Health Access Program*
2003	Physician Volunteer Zwedru, Liberia *Merlin*
2000 - Present	Trauma Director, Emeritus Trauma Management Program Thai-Burma Border *Community Partners International-Global Health Access Program/ Access Aid International*
1996 - 1999	Humanitarian Relief Emergency Medicine Physician Bosnia, Albania, Kosovo *International Medical Corps*
1997 - 1998	Visiting Lecturer China and South Korea *Emergency International*
1992 - 1993	Emergency Medicine Residency Program Design Costa Rica *Project HOPE*

RESEARCH

1/91 - 6/93	Access to Health Care: Study Investigating Emergency Department Patients Who Leave the Hospital Prior to Being Seen, Harbor / UCLA Medical Center. Supervisor: Carl Stevens, MD, MPH
8/85 - 8/86	Research Fellow – Investigation of Tumor Associated Antigens and Oncogene Related Protein in Bladder Cancer, UCLA. Supervisor: John L. Fahey, MD

1/86 -8/86

Project Manager – Evaluation of Immunological Changes in AIDS, UCLA.
Supervisor: Janis V. Giorgi, Ph.D.

6/82 - 6/83

Research Assistant – Investigation of *Pseudomonas aeruginosa* Cell Surface Antigens, UC Riverside.
Supervisor: Neal L. Schiller, Ph.D.

PUBLICATIONS

Washington, C.H., Tyler, F.J., Davis, J., Shapiro, D.R., Richards, A., Richard, M., Lee, T.J., Colton, T.L., Berk, L., Rauch, L., Shwe Oo, E.K., Hahn, R., and Stock, L.M.: Trauma Training course: Innovative teaching models and methods for training health workers in active conflict zones of Eastern Myanmar. International Journal of Emeregncy Medicine 2014, 7:46.

Lim, A.G., Stock, L., Shwe Oo, E.K., and Jutte, D.P.: Trauma and Mental Health of Medics in Eastern Myanmar's Conflict Zones: A Cross-sectional and Mixed Methods Investigation. Conflict and Health 2013, 7:15.

Richard, A.J, Lee, C., Richard, M., Shwe Oo, E.K., Lee, T., and Stock, L.: Essential Trauma Management Training: Addressing Service Delivery Needs in Active Conflict Zones in Eastern Myanmar. Human Resources for Health 2009, 7:19.

Stock, L., Bradley, G.E., Lewis, R., Baker, D., Sipsey, J. and Stevens, C.S.: Patients Who Leave Emergency Departments Prior to Evaluation: Magnitude of the Problem in Los Angeles County. Annals of Emergency Medicine 23: 294 - 298, 1994.

Liu, B.C.S., Neuwirth, H. Zhu, L.W., Stock, L.M., deKernion, J.B. and Fahey, J.L.: Detection of Onco-Fetal Bladder Antigen in Urine of Patients with Transitional Cell Carcinoma. The Journal of Urology 137: 1258-1261, 1987.

Stock, L.M. Brosman, S.A., Fahey, J.L. and Liu, B.C.S.: RAS Related Oncogene Protein as a Tumor Marker in Transitional Cell Carcinoma of the Bladder. The Journal of Urology 137: 789-792, 1987.

Borowski, R.S., Stock L.M. and Schiller, N.L.: Development of an Enzyme-Linked Immunosorbent Assay for Studying *Pseudomonas aeruginosa* Cell Surface Antigens. Journal of Clinical Microbiology 19: 736-741, 1984.

HONORS

Honor Recognition Award, 2008, Antelope Valley Partners for Health

Volunteer Teacher of the Year Award, 2009-2010 and 2006-2007 Department of Emergency Medicine, Harbor UCLA Medical Center

Humanitarian Award, Inaugural Year, 2005, California Chapter, American College of Emergency Medicine

International Humanitarian of the Year, 1999, Antelope Valley Chapter, American Red Cross

MEMBERSHIP

Fellow, American College of Emergency Physicians
Member, Society for Academic Emergency Medicine
Health Advisory Team Member and Trauma Director Emeritus, Community Partners
International-Global Health Access Program
Global Medical Director, Access Aid International

SELECTED LECTURES

Emergent Field Medicine, Global Health Day, Grand Rounds, Department of Emergency Medicine, Harbor UCLA Medical Center, 2009

Emergency Physicians and International Humanitarian Assistance, The Underserved Medicine Course, UC Santa Barbara, Direct Relief International, 2009

Emergency Physicians and International Humanitarian Assistance, Wilderness Medicine Interest Group, David Geffen School of Medicine at UCLA, 2008

Emergency Physicians and International Humanitarian Assistance, Highland Emergency Medicine Residency Grand Rounds, Oakland, California, 2008

Responding to Complex Human Emergencies: An Emergency Medicine Physician's Experiences and Insights, Fifth Annual Crossroads Speaker Series, The Jesuit Spirituality Center, Portland, Oregon, 2007

Medical and Ethical Issues in the Kosovo Theater of War, Bioethics Conference, Center for Health Care Ethics, Cedars-Sinai Medical Center, 2000

The Kosovo Crisis: International Emergency Medicine on the Frontlines of Human Disaster, Scientific Assembly, American College of Emergency Physicians, 1999

EMS/T Committee Representation

BY COUNTY

As of March 25, 2015

HOSPITAL/HEALTH SYSTEM MEMBERS	
Free-Standing Facility	2
Large Hospital System	7
Private Facility	0
Small/Rural Facility	0
Special Facility	0
University/Teaching Facility	3
ADMINISTRATIVE REPRESENTATIVES	
Professional Group Specializing in EMS/T	1
Public Institution	3
State Trade Association	2
REGIONAL REPRESENTATIVES	
Regional Representatives	3
OTHER	
Ambulance Services	1
CHA Staff	3
TOTAL COMMITTEE REPRESENTATION	25

Denotes number of hospitals/health systems represented within that county.

CHA Member/ED Breakdown

Mar-15

HOSPITAL COMMITTEE MEMBER:

Nancy Blake		Children's Hospital Los Angeles
Stacey Hanover		Children's Hospital Oakland
Frank Maas		Children's Hospital of Orange County
Aaron Wolff		Dignity Health
Susan Thompson		Huntington-Memorial Hospital
Connie Cunningham		Loma Linda University Med Center
Karla Earnest		Lucile Packard Children's Hospital
Kimberly Murphy		Providence Holy Cross Medical Center
Kimberlee Roberts		Scripps Memorial Hospital La Jolla
Mark Mayes		UCLA Health System

ED TYPE BY MEMBER:

Nancy Blake	Children's Hospital Los Angeles	Pediatric/Trauma
Stacey Hanover	Children's Hospital Oakland	Pediatric/Trauma
Frank Maas	Children's Hospital of Orange County	Pediatric/Trauma
Karla Earnest	Lucile Packard Children's Hospital	Pediatric/Regular
Kimberlee Roberts	Scripps Memorial Hospital La Jolla	Regular
Aaron Wolff	Dignity Health	Trauma/Regular
Susan Thompson	Huntington-Memorial Hospital	Trauma/Regular
Mark Mayes	UCLA Health System	Trauma/Regular
Kimberly Murphy	Providence Holy Cross Medical Center	Trauma/Regular
Connie Cunningham	Loma Linda University Med Center	Trauma/Regular

NON-HOSPITAL COMMITTEE MEMBER:

Vivian Reyes		CAL ACEP
Frederick Dennis		Cal ACEP
Heather Venezio		CAL ENS
Eric Morikawa		California Department of Public Health
Farid Nasr		California EMS Authority
BJ Bartleson		California Hospital Association
Cheri Hummel		California Hospital Association
Ross Fay		CALSTAR
Stuart Buttlaire		CHA/CBH Liason
Tom McGinnis		EMSA
. Jaime Garcia		HASC
Judith Yates		HASD&IC
Jo Coffaro		HCNCC
Jim Pierson		Medic Ambulance

GUIDELINES FOR THE

CALIFORNIA HOSPITAL ASSOCIATION'S EMS/TRAUMA COMMITTEE

Updated 2/27/06

I. NAME

The name of this committee shall be the CHA EMS/Trauma Committee.

II. MISSION

The EMS/Trauma Committee represents CHA members that provide emergency medical and/or trauma services in the State of California, and serves in an advisory capacity to the CHA Board of Trustees regarding EMS/Trauma member needs, policies and legislation. The purposes of the Committee shall be:

- to serve as a forum for all CHA members interested in EMS/Trauma to receive and exchange information, adopt policies and positions, guide management, adopt strategies and serve as the primary public policy arm of CHA for emergency medical services and trauma issues;
- to provide CHA member EMS/Trauma providers with a statewide structure dealing with the issues important to their interests;
- to create a representative form of leadership which is based on participation of all its members;
- to provide direct input to the CHA Board of Trustees; and
- to provide a unified voice on behalf of CHA members offering EMS/Trauma services.

III. COMMITTEE

The committee shall consist of a maximum of 22 representatives from California organizations with related interests.

A. MEMBERSHIP

1. Membership on the CHA EMS/Trauma Committee shall be based upon membership in CHA, and reserved for those members.

2. The Committee shall consist of various representatives from large hospital systems, public institutions, private facilities, free-standing facilities, small and rural facilities, university/teaching facilities, specialty facilities and a representative from a professional group specializing in EMS/Trauma issues.

3. Appointment of members to the Committee will follow the CHA Guidelines for Committee Membership.

B. TERMS OF THE COMMITTEE MEMBERS

1. As members leave the Committee, vacancies shall be filled. It is understood that a member forfeits his/her seat if they no longer serve in the capacity, or represent a facility that is not a CHA member.

2. Committee members with specialized skills, knowledge, or professional associations may serve on the committee as ex-officio members. Ex-officio members are not subject to the above terms. These determinations shall be made by CHA.

3. Provider representatives who transition from one position to another are welcome to attend committee meetings during their transition; however, this should not exceed two consecutive meetings.

4. Provider representatives who misrepresent their organization's position are subject to review and dismissal from the committee.

C. COMMITTEE MEETINGS

1. Meetings of the Committee shall be held quarterly.

2. Provider representatives may send an appropriate substitute to the meetings when they are unable to attend. To maintain continuity for Committee meetings, this should be used sparingly, not to exceed two consecutive meetings.

3. Three consecutive unexcused absences by a Committee member may initiate a review by the Chair and CHA staff for determination of the Committee member's continued service on the Committee.

4. Special meetings may be scheduled by the Chair, majority vote or CHA staff.

D. VOTING

1. Voting rights shall be limited to members of the Committee, and each member present shall have one vote. Voting by proxy is not acceptable.

2. All matters requiring a vote of the Committee must be passed by a majority of a quorum of the Committee members only at a duly called meeting or telephone conference call.

E. QUORUM

Except as set forth herein, a quorum shall consist of the majority of the Committee membership in attendance.

F. MINUTES

Minutes of the Committee shall be recorded at each meeting, disseminated to the membership, and approved as disseminated or as corrected at the next meeting of the Committee.

IV. OFFICERS

The officers of the Committee shall be the committee chair, co-chair, and CHA staff.

Except as provided herein, the chair and co-chair shall be elected by the Committee for a two-year term.

The chair officers vacate their Committee positions upon election, and their seats shall be filled through the nominating and election process. The past-chairs will be invited by the Committee to serve as ex-officio members.

Should a chair or co-chair vacate his/her position prior to the end of the term, a nominating committee will convene to select a replacement, and assume a two-year term of office.

V. COMMITTEES

For special and specific purposes, the chair or CHA staff may appoint a committee or ad hoc on task force. Membership may be expanded to non-members of the Committee.

VI. GENERAL PROVISIONS

The strategic plan defining the goals, objectives, and work plans shall be developed annually by the CHA staff and approved by the Committee. Quarterly updates and progress reports shall be completed by the Committee and CHA staff.

Staff leadership at the state level shall be provided by CHA with local staff leadership provided by HCNCC, HASD&IC, and HASC. The primary office and public policy development and advocacy staff of the Committee shall be located within the CHA office.

The Committee staff shall be an employee of CHA.

VII. AMENDMENTS

These Guidelines may be amended by a majority vote of the members of the Committee at any regular meeting of the Committee.

VIII. LEGAL LIMITATIONS

Any portion of these Guidelines which may be in conflict with any state or federal statutes or regulations shall be declared null and void as of the date of such determination.

Any portion of these Guidelines which are in conflict with the Bylaws and policies of CHA shall be considered null and void as of the date of the determination.

Information provided in meetings is not to be sold or misused.

IX. CONFIDENTIALITY FOR MEMBERS

Many items discussed are confidential in nature, and confidentiality must be maintained. All Committee communications are considered privileged and confidential, except as noted.

X. CONFLICT OF INTEREST

Any member of the Committee who shall address the Committee in other than a volunteer relationship excluding CHA staff and who shall engage with the Committee in a business activity of any nature, as a result of which such party shall profit pecuniarily either directly or indirectly, shall fully disclose any such financial benefit expected to CHA staff for approval prior to contracting with the Committee and shall further refrain, if a member of the Committee, from any vote in which such issue is involved.

CHA EMS/Trauma Committee Proposed Workgroups

Workgroups inform CHA on issues pertaining to legislation, regulations and advocacy. Please sign-up for a workgroup where you feel your knowledge would be put to best use.

EMS-C

ED-General

Trauma

EMS Issues

Undefined

EMS/TRAUMA COMMITTEE
MEETING MINUTES
September 10, 2014 / 10:30 am to 2:30 pm
California Hospital Association

Members Present:	Jo Coffaro (Phone), Karla Earnest (Phone), Ross Fay, Frank Maas, Mark Mayes, Daman Mott, Kimberly Murphy, Farid Nasr, Vivian Reyes (Phone), Janet Rimicci (Phone), Kimberlee Roberts, Heather Venezio, Judith Yates, Terri Gill, Jonathan Jones
Members Absent:	Stuart Buttlaire, Connie Cunningham (phone) , Stacey Hanover (phone), Eric Morikawa, James Pierson, Cheri Hummel, Frederick Dennis, Aaron Wolff (phone), Nancy Blake, Gerald Bracht, , Andrew Greene, Darin Huard, Sharon Rudnick,
Guests:	Julie Hamilton (Emergency Medical Services Authority)
CHA Staff:	BJ Bartleson, Amber Morton, Debby Rogers, Lois Richardson, Rhonda Filipp, Cheri Hummel (absent), Sheree Kruckenberg, David Perrott (absent)

DRAFT

I. CALL TO ORDER/INTRODUCTIONS

A. The meeting was called to order at 10:26 a.m. Introductions were made all around. Member updates were reviewed.

   a. Roster

   b. Member Updates

B. Review of Committee Mission & Objectives

C. Content Champions/Thought Leaders/Workgroup

II. REVIEW OF MINUTES OF PREVIOUS MEETING

A. Minutes

IT WAS MOVED, SECONDED AND CARRIED:

- *To approve the minutes of June 11, 2014 EMS/T.*

III. OLD BUSINESS

A. Member Map:

Special attention was brought to the current membership map. There is a need to fill-in the gaps in membership, especially ED directors and managers located in the center of state. The request was made for members to reach out to colleagues and contacts who may be interested in being active members.

IV. NEW BUSINESS

A. Trauma Quality Improvement Program (TQIP) Presentation – Jonathan Jones

Mr. Jones presented on TQIP from the perspective of the Trauma Center. The discussion following the presentation established that TQIP is a valuable asset in measuring hospital quality across the state, but there are some barriers to gaining entry to all hospitals. These barriers include a comprehensive discussion on the return on investing in TQIP and unease of the hospital with the potential use of recorded data both for HIPPA and LEMSA standards.

It was discussed that a good first step in creating a whole state regulating standard would be to define basic concepts such as: what is a trauma patient. In addition the data provided by Ms. Jones' system could be used to promote the idea of founding guiding principles in California hospital regulation.

Action: Ms. Bartleson to send state trauma plan to Rural Hospital Committee.

B. HIE

1. Barriers and Core Measures: - Julie Hamilton Emergency Medical Services Authority (EMSA)

Hospitals are overwhelmed with too many patients throughout California. In the Los Angeles region (including Orange County, Riverside, San Berdino, San Diego and Ventura) the hospitals are participating in a bidirectional patient program. This includes initiating a Disaster Portal that allows providers to login during a disaster and track bed availability, patient movement and help families find victims. Ms. Hamilton is encouraged by the sample location as they have 56% of the state's population, 38 million people, and a diverse population type. Contra costa county with Kaiser program currently running.

Barriers have included hospitals holding reservations about HIPA compliance and patient privacy violent ion by sharing this data. Ms. Hamilton indicated that this issue would be covered in the EMSA's November Conference (November 17-19, 2014). November 17th is to be a "boot camp" of HIE and what is happening in California.

V. LUNCH

VI. NEW BUSINESS CONTINUED

A. Strategy for National EMS Culture of Safety - Rhonda Filipp

Ms. Filipp presented on AHRQ Health Care Innovations Exchange tools and innovations. Details of which can be found in the September 10, 2014 meeting pack on page 244.

The conversation following the presentation brought up concerns about the protection of patient information provided downstream in the patient profile. Mr. Mott brought to the table that EMS services need to be included in the solution. Ms. Yates asked how the workplace safety component was being addressed within this system. Ms. Bartleson indicated that it was an overall culture change that would affect the workplace environment.

Mr. Jones advocated for including definitions of EMS activities to ease communication and reporting to the various stakeholders.

B. 2015 Meeting Schedule

The following meeting dates were purposed for 2015. It was asked that all members review and verify the dates are acceptable.

Date	Location
WEDNESDAY, MARCH 25, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, JUNE 24, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, SEPTEMBER 23, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
SUNDAY, DECEMBER 6-8, 2015 10:30 AM – 2:30 PM	**Joint Meeting – EMST/Center for Behavioral Health** Location TBD

C. HIE Legal Parameters – Lois Richardson

Ms. Richardson explained the complications with answering the question: Can hospitals release identifiable info for quality improvement to LEMPSA and others? No sharing is advices on substance abuse or HIV patients. Beyond that, hospitals can share information for quality improvement purposes with EMS providers as long as they have a patient in common. The issue comes on determining if how far down the patient stream the hospital is protected.

CMIA has two new pertinent sections: 5610C4 and 5610C14. Civil 5610C4 is meant to allow the sharing of patient information with insurers and providers, but not technically to be used by hospitals for cross provider quality improvement. It is a loop hole in the law that is not necessarily valid. 5610C14 allows that patient information may be disclosed where otherwise authorized or required by law.

HIPPA augments this issue. The original intent of HIPPA was to provide a floor for information sharing not to prevent sharing completely. That said, the legal experts vary on where HIPPA allows or rather stops the leagal sharing of patient information for quality evaluation.

Action: Discuss draft bill language to outline sharing rules and common determinative language.

VII. Old Business

A. Community paramedicine – BJ Bartleson

Ms. Bartleson reviewed that CHA has submitted comments to OSHPD regarding their community paramedicine program. It is currently believed that all 12 items in the purposed program will be moving forward.

B. Walltime Toolkit – BJ Bartleson

Ms. Bartleson distributed versions of the toolkit to those members present and thanked them for their help in creating this valuable tool.

VIII. Standing Items

A. Joint Commission Throughput EP

CEO's have stated that the number one issue is throughput. Thr group discussed creating a common language and toolkit guide similar to the Walltime Toolkit just released.

IX. New Business continued – Sheree Kruckenberg

A. Psychiatric Emergency Services

There are new statues aimed at modernizing 5150. This will only reflect pre-72 hour assessment, confirmation through the law enforcement and determination. Statute VII C will encourage implementation of independent phycology departments. These facilities would not take an ER patient that had physical issues but would be open 24-7, bound by intalla, offer to assess every one, can bill everyone, have law enforce drop off and be located on or near hospital. CHA has offered comments on the statues to hospitals and LEMSA's.

B. SB 82 Grants

Money is available to support the founding of psychiatric wings. In the documents attached to the September meeting packet is a list of hospitals who have received the fund and information on the funds intent as well as application process. Ms. Kruckenberg encouraged each member to see if their hospital has been granted funds and become involved in the process as soon as possible.

X. REGULATORY UPDATES – Farid Nasr

A. STEMI

STEMI stroke regulations are going back to revised draft new addition of CA rule making log book. Mr. Nasr hopes to do another public comment request in the end of October and open OAL by end of this year.

B. State trauma Plan

Mr. Nasr noted that comments are being reviewed for the State Trauma Plan. It is anticipated that the plan will be put out for another public comment period in the end September/early October and will be submit for final review in December.

XI. ROUND TABLE DISCUSSION

XII. NEXT MEETING

Sunday, December 7, 2014 – Redondo Beach

XIII. ADJOURNMENT

Having no further business, the meeting adjourned at 2:25 p.m.

BJB:am

EMS/TRAUMA COMMITTEE
MEETING MINUTES
December 7, 2014 / 4:00 pm – 6:00 pm
California Hospital Association
Location: Crowne Plaza, Redondo Beach

Members Present:	Frank Maas, Daman Mott, James Pierson
Members Absent:	Nancy Blake, Stuart Buttlaire, Jo Coffaro, Connie Cunningham, Frederick Dennis, Karla Earnest, Ross Fay, Andrew Greene, Stacey Hanover, Darin Huard, Jonathan Jones, Mark Mayes, Eric Morikawa, Kimberly Murphy, Farid Nasr, James Pierson, Vivian Reyes, Janet Rimicci, Kimberlee Roberts, Sharon Rudnick, Bonnie Sinz, Heather Venezio, Aaron Wolff
Guests:	Jan Ogar - Clinical Coordinator, San Mateo County EMS Agency (phone); Debby Rogers – CHA Vice President, Clinical Performance and Transformation
Regional Association Representatives:	Jaime Garcia, Judith Yates
CHA Staff:	BJ Bartleson, Marla Bartle, Rhonda Filipp (absent), Cheri Hummel (absent), Sheree Kruckenberg (absent), David Perrott (absent)

I. CALL TO ORDER/INTRODUCTIONS

A. The meeting was called to order at 4:15 p.m. Introductions were made. Member updates were reviewed.
B. As discussed previously, several openings are available on the committee. Members are encouraged to submit candidate recommendations to BJ Bartleson for consideration by the committee.

II. REVIEW OF MINUTES OF PREVIOUS MEETING

A. Due to a lack of a quorum, minutes of the September 10, 2014 EMS/T Committee were tabled until the next meeting.

III. OLD BUSINESS

A. ED Overcrowding – *Tabled*

DRAFT

B. Community Paramedicine Update

Mr. Pierson reported that a recent OSHPD open forum public meeting on the pilot sites has resulted improved clarity on paramedicine process, i.e. education, and paramedic ratios. The next public hearing is scheduled for January 22, 2015. Patient safety is a key factor in this program and partnering with home health and social services will be a catalyst towards that goal. Additionally, making sure paramedic responders are fully trained with current issues is vital. Making the public aware of calling through the CAD instead of 9-1-1 will take time. Mr. Pierson also stated that working with other pilot groups through "Chatter Group" is helping information exchange between pilot groups.

C. Walltime Update –*Tabled*

IV. NEW BUSINESS

A. AHRQ –*Tabled*

B. EMSA HIE and Proposed Legislation

Ms. Bartleson discussed the EMSA HIE Summit she and Lois Richardson attended in November, and the "HIE for Quality Improvements" Powerpoint Presentation. Ms. Bartleson welcomed Ms. Ogar to the meeting. Ms. Ogar was instrumental in the innovative process manner San Mateo's EMSA used to share STEMI data.

ACTION ITEM: MS. BARTLESON WILL SCHEDULE A CALL BETWEEN HER, LOIS RICHARDSON AND MS. OGAR TO DISCUSS HIE SOLUTIONS

C. Ebola –*Tabled*

D. FSED –*Tabled*

E. PES –*Tabled*

F. ED Cal Noc Outcomes

Ms. Rogers asked members about what data could CalNoc provide that would be instrumental in assisting CHA EMS/T and Behavioral Health groups on important issues. Mr. Maas stated that accurate information is needed on-line. Ms. Bartleson stated that ED stories are needed. Ms. Rogers discussed CalNoc patient boarding data. Mr. Mott discussed the need to define Level 3 Triage due to the variables of level of treatment. Ms. Rogers stated that CalNoc reporting needs to be more granular to include psych admits and transfers.

DRAFT

V. ROUND TABLE DISCUSSION - None

VI. NEXT MEETING

Wednesday, March 25, 2015 – Sacramento, CHA Board Room, 8th Floor

VII. ADJOURNMENT

Having no further business, the meeting adjourned at 5:45 PM

BJB:mb rev 1/9/15

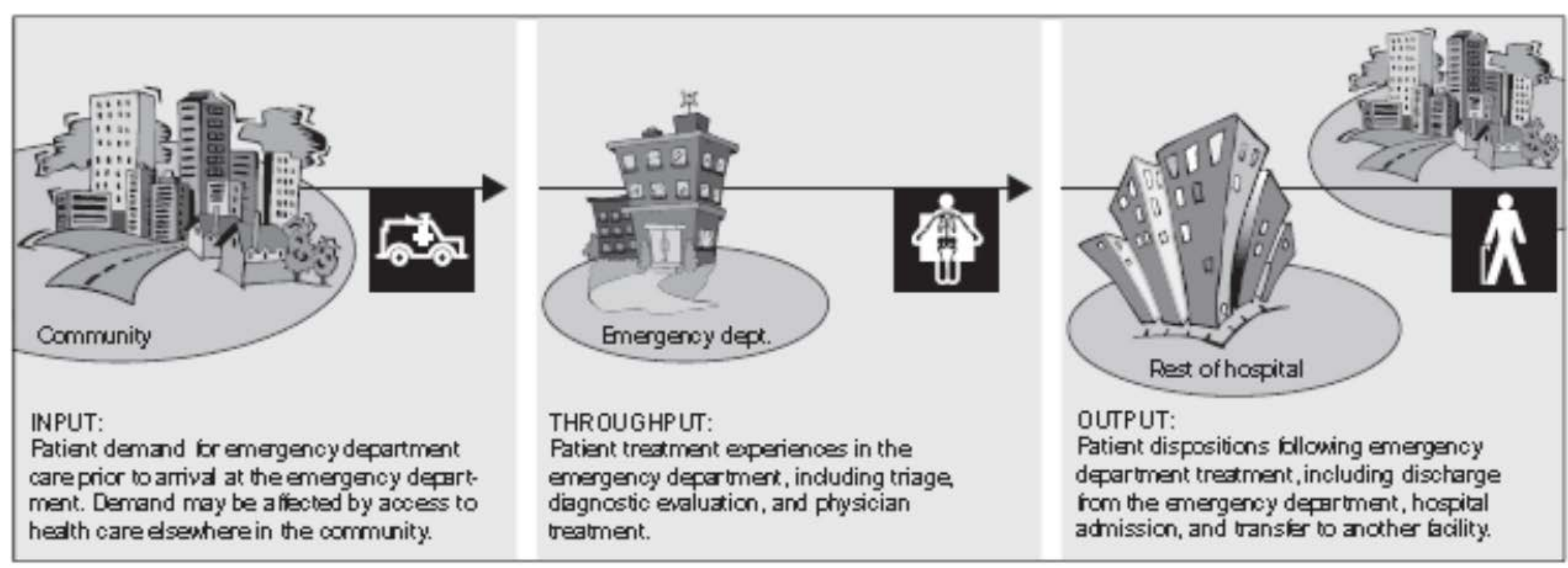
Factors Associated with Emergency Department Boarding Time in California Hospitals

Debby Rogers, RN, MS, FAEN
UCSF Doctoral Student

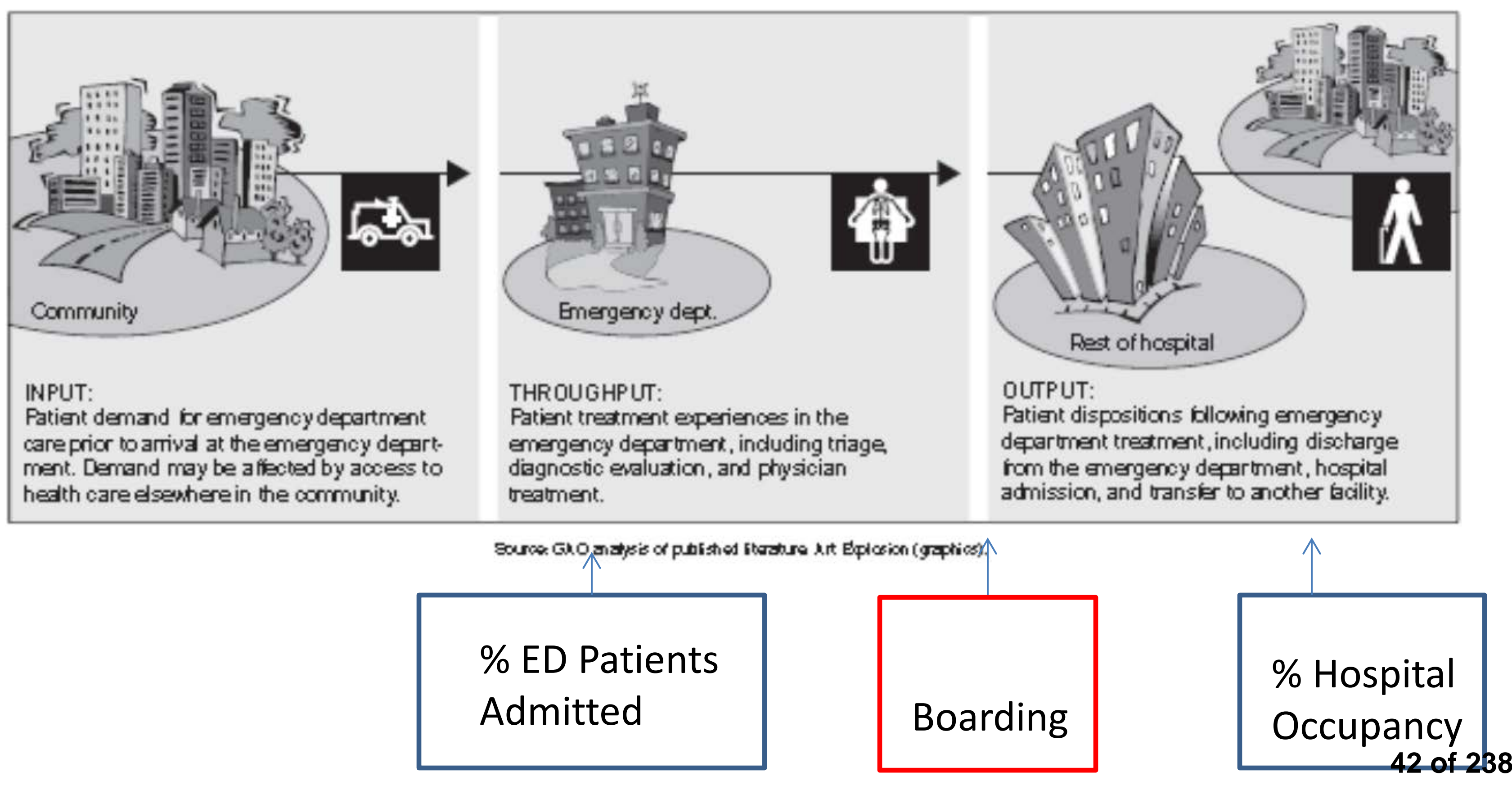
Background

- Emergency Department crowding is an national public health crisis (IOM, 2006).
- Holding patients who need inpatient admission to the hospital is a major cause of ED crowding (IOM, 2006; GAO, 2009).
- Boarding is associated with:
  - Higher patient mortality (Singer, et al., 2011).
  - Decreased patient/staff satisfaction (Pines, et al., 2008).
  - Increased medication errors (Falvo, et al., 2006).

ED/Hospital Patient Flow



ED/Hospital Patient Flow

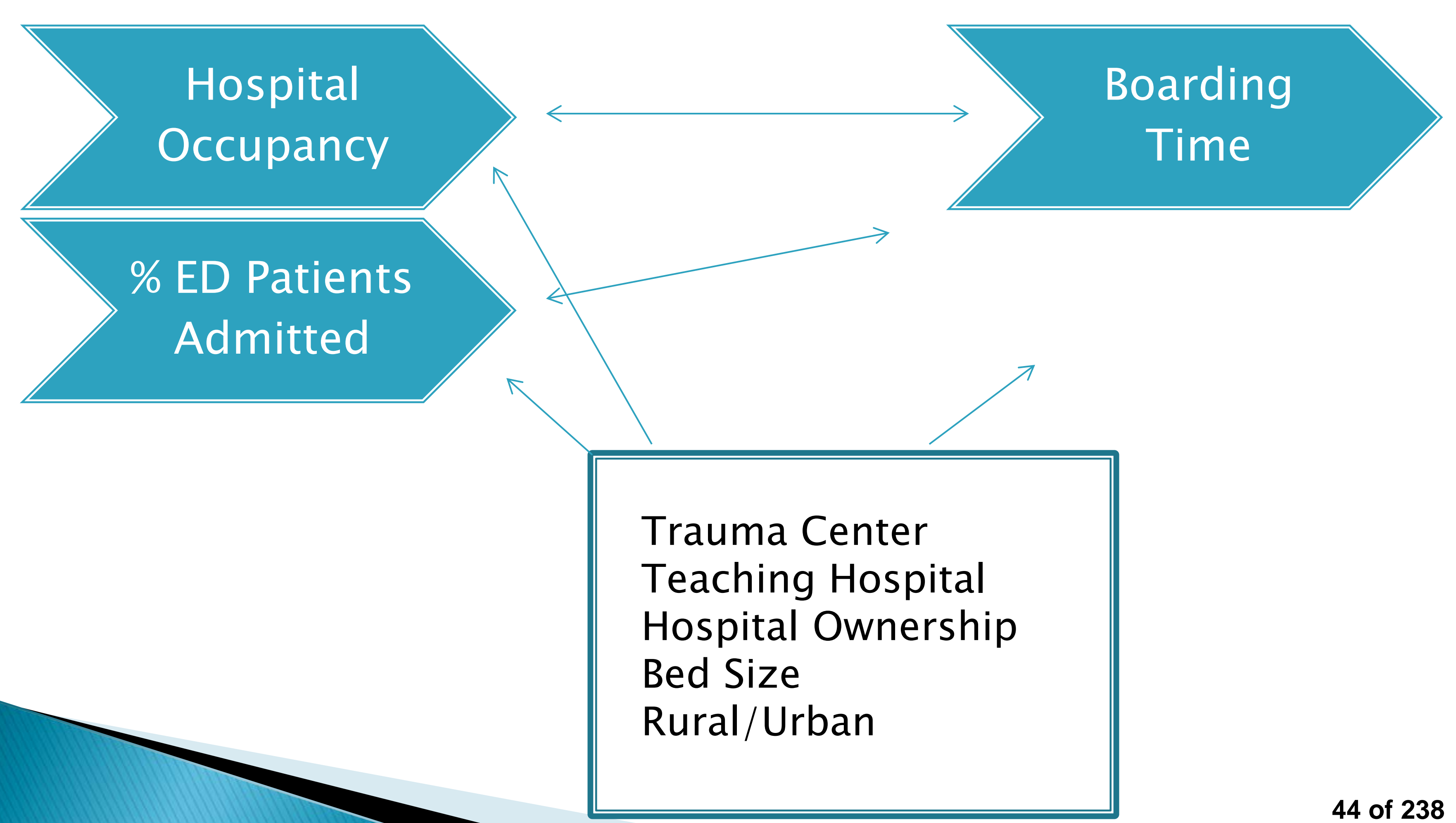


Centers for Medicare and Medicaid

Medicare.gov/ Hospital Compare

	Hospital A	Hospital B	Hospital C	State	National
Average time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A* ***lower*** *number of minutes is better*	205 Minutes	262 Minutes	76 Minutes	California average: 126 Minutes	average: 97 Minutes

Conceptual Model



Motivation

- One of the first studies to use the new CMS boarding measure.
- Hospital improvement strategies would benefit from understanding any associations.
- If there are factors outside the control of the hospital that associate with boarding, policy makers could review measures in the reporting system.

Research Questions

- Is there an association between hospital occupancy and boarding times?
- Is there an association between the percent of ED patients admitted and boarding times?

Data

Centers for Medicare and Medicaid (CMS) boarding times (collected 4/1/13-3/31/14).

Office of Statewide Planning and Development Utilization Report (collected 1/1/13-12/31/13).

Measures

- Annual average boarding time
- Annual percentage of hospital occupancy
- Percentage of hospital admissions generated from the ED
- Hospital bed size
- Trauma center designation
- Teaching hospital
- Rural/urban- MSSA designation
- Hospital ownership
  - Not for profit
  - Public (city/county/UC)
  - Investor
  - District

Sample – Included and Excluded Hospital Descriptive Statistics

Table 1 Descriptive statistics for hospitals included in the study

Variable	N Included Hospitals	Percent	Cumulative Percent	N Excluded Hospitals	Percent Excluded From Category
Hospital Bed Size					
1-49	16	5.9	5.9	20	56
50-99	19	7.0	12.9	12	39
100-149	53	19.6	32.5	10	16
150-199	37	13.7	46.1	9	20
200-299	60	22.1	68.3	5	9
300-499	67	24.7	93.0	4	6
500+	19	7.0	100	2	10
Total	271			62	

Descriptive Statistics Study Variables

Table 2. Descriptive statistics for study variables

Variable	N	Min	Max	Mean	Standard Deviation
Boarding time	271	28	358	132.5	67.1
% of hospital occupancy	271	6	96	51.1	16.0
% of ED patients admitted	271	2	39	14.4	6.1
Hospital bed size	271	11	886	246.2	153.8

Variable	N	Percent
Hospital ownership		
Not for profit	171	63.1
Investor	55	20.3
District	25	9.2
Publicly owned	20	7.4
Trauma center	64	23.6
Non-trauma center	207	76.4
Teaching hospital	24	8.9
Non-teaching hospital	247	91.1
Rural MSSA	51	18.8
Urban MSSA	220	81.2

Correlation Matrix

Table 3 Correlation matrix with CMS boarding time with other study variables

	CMS boarding time correlation	N	Sig
Hospital occupancy	**.380****	**271**	**.000**
% Admit from ED	**.112**	**271**	**.065**
Trauma center	**.252****	**271**	**.000**
Teaching hospital	**.319****	**271**	**.000**
Hospital ownership	**-.123***	**271**	**.042**
MSSA designation	**.091**	**271**	**.134**
Total hospital licensed beds	**.312****	**271**	**.000**

**p<.01, *p<.05

Results Model Summary

Table 4 Ordinary least squares regression for boarding times and study variables model summary

	Model 1***	Model 2***	Model 3***
Hospital occupancy	1.64***	1.64***	1.247***
% ED patients admitted		-.023	-1.014
Hospital bed size			.094**
Trauma center designation			9.75
Teaching hospital			.172
Control/ownership Non-profit (comparison)			____
District			-11.30
Public (county/UC)			83.60***
Investor			5.47
MSSA rural area (comparison)			____
MSSA urban area			-.10.47
N	271	271	271
R2	.144	.144	.322
Adjusted R2	.141	.138	.299
F change	45.41***	.001	9.76***

*p<.05 **p<.01 *** p<.000

Interpretation

- Higher hospital occupancy is associated with longer boarding time. Hypothesis upheld. Hospitals can use this information to develop strategies to decrease boarding and increase patient safety.

- Percentage of ED patients was not associated with boarding time. Hypothesis rejected. May not capture the full breadth of hospital admission flow.

- Public hospitals and larger hospitals associated with longer boarding times. This could negatively impact these hospitals in CMS reporting/reimbursement program.

Limitations

- CMS boarding measure is relatively new and lacks reliability.
- Annual data does not reflect the dynamic nature of ED/hospital/seasonal fluctuations.
- Does not include ‘observation’ status patients.
- Missing data/excluded hospitals.

Future Research Should Consider

- Stratify occupancy rates for by hospital unit.
- Payer source.
- Scheduled admissions.
- Patient severity of illness/injury.

Office of Statewide Health Planning and Development

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November 14, 2014

Howard Backer, MD, MPH
Director
Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

RE: Health Workforce Pilot Project (HWPP) #173 – Community Paramedicine Approval with Modifications

Dear Dr. Backer:

I am pleased to announce the approval of the Emergency Medical Services Authority (EMSA) application, HWPP #173 Community Paramedicine with modifications. This project will test, demonstrate, and evaluate the practice of Community Paramedicine in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department;
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments;
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital; and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The Emergency Medical Services Authority, as the project sponsor, is approved to proceed with all of the concepts and pilot sites proposed in its application for HWPP #173 provided that all of the modifications specified in the OSHPD staff recommendation memorandum dated October 13, 2014 (attached for reference) are implemented. Those recommendations are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current

regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.

- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.
- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
  - When was the patient discharged?
  - Where was the patient discharged (i.e. home or hospitalized)?
  - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

Additionally, all of the following five provisions must be met:

- In addition to the requirements specified in the OSHPD staff recommendation memorandum dated October 13, 2014, the sponsor shall ensure that all project sites modify the Informed Consent form to read as follows:

  "Patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. An exception to this requirement will be allowed for study sites where the main objective is to evaluate alternative destinations for

patients with mental health issues that potentially prevent them from having adequate capacity to consent, and where paramedics participating in the Behavioral Health Pilot Project have completed a specified Psychiatric Emergency Response Team Training Course in Behavioral Health issues in addition to the completion of the Community Paramedicine Core Training. In these cases, efforts should still be made to obtain informed patient consent for the study, but inability for psychiatric reasons will not prevent the patient from participating. Patients in these mental health projects with other reasons for incapacity, such as unresponsiveness, and patients in all other projects cannot be included in the pilot projects unless consent is lawfully given."

- The sponsor shall work with the project sites to develop further consistency with the medical criteria, protocols and training for similar concepts that are being tested.
- The sponsor shall ensure that all alternate destination concepts (CP 001, CP 003, CP 009 and CP 012) send additional personnel to both the statewide and local training.
- The sponsor shall require all sites to pursue local Institutional Review Board (IRB) approval.
- OSHPD will ensure that data safety monitoring is included in the responsibility of the HWPP #173 Advisory Committee, through site visits and data submission reports.

As was stated in the staff recommendation, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Program Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and make available its findings to the general public.

We appreciate your willingness to modify aspects of your project as a result of the review and comment phase of the application process. This approval is granted pursuant to Health and Safety Code Section 128125 of the governing administration of the HWPP Program.

This approval is effective immediately and will expire on November 14, 2015. You will be asked to submit reports and data that describe the progress in meeting objectives. If an extension of time is needed, you will be required to provide this Office with information to justify the request by September 15, 2015.

OSHPD will monitor HWPP #173 through written reports and site visit evaluations. In addition, we expect the Advisory Committee to assist the Office with the monitoring and development of guidelines to strengthen protocols, if possible, pursuant to their findings.

Ms. Kristen M. Widdifield will serve as the Program Administrator and you may contact her with any questions at (916) 326-3718 or Kristen.Widdifield@oshpd.ca.gov.

Very truly yours,

ROBERT P. DAVID
Director

cc: Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division

To: Robert P. David
Director

Date: October 13, 2014

Via: Stephanie Clendenin
Chief Deputy Director

From: Lupe Alonzo-Diaz
Deputy Director
Healthcare Workforce Development Division

Subject: Recommendation Regarding Health Workforce Pilot Project (HWPP) #173 Community Paramedicine Proposal

On December 28, 2013, the California Emergency Medical Services Authority (EMSA) submitted an application for the HWPP Program's consideration for status as a pilot project. EMSA proposes a pilot project regarding the practice of Community Paramedicine (CP) in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department,
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments,
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital, and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The HWPP Program has completed a review process for application HWPP #173 in accordance with California Health and Safety Code Section 128175. This included:

- A review of the application to ensure that it met statutory and regulatory criteria,
- Seeking input from relevant healing arts licensing boards and professional organizations,
- Posting the application for public comment before and during the public meeting and public hearing,
- Holding a public meeting on April 9, 2014 to permit the HWPP #173 sponsor to present and receive public input on the application, and
- Holding a public hearing on July 30, 2014 by a disinterested state government official as is required for projects sponsored by a state agency.

I recommend approval of the HWPP #173 application for pilot project status with the following modifications and provisions. This recommendation is based on the HWPP

Program's review and consideration of the information presented via the review process.

The required modifications and provisions are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.
- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.

- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
  - When was the patient discharged?
  - Where was the patient discharged (i.e. home or hospitalized)?
  - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

HWPP Program Monitoring
If the project is approved, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and
- Make available its findings to the general public.

Wall Time Collaborative Meeting
February 10, 2015

Ambulance Patient Delay Follow-up Meeting
EMSA Office
10901 Gold Center Drive , Suite 400
Rancho Cordova, CA 95670

Wall Time Collaborative Activities for the Day

- Introductions
- Meeting Goals and Objectives
- Work-To-Date
- Toolkit Introduction
- Statewide Activity
- Lunch
- Learning Laboratories
- Next Steps
- Adjournment

Wall Time Collaborative Goals and Objectives for Today

- Reconvene the original collaborative members and other interested stakeholders to review and discuss the work to date
- Officially unveil the *Toolkit to Reduce Ambulance Patient Offload Delays in the ED*
- Discuss statewide activity
- Learn from three selected LEMSA's/Hospital Groups
- Discuss next steps

CHA-EMSA Wall Time Collaborative

Triple Aim

Toolkit 2014

- Distribution
- Local process improvement activities, ongoing

Stakeholder Reconvening

2/2015

Toolkit Wall Time Collaborative

2014

Workgroups

2013-2014

- Legal/Regulatory
- Best Practices
- Metrics

Initial Stakeholder Meeting

3/2013

Wall Time Collaborative

- Original Wall Time Collaborative Goals
  - ✓Develop standardized language, definitions, metrics and reporting opportunities for ambulance patient throughput and delays
  - ✓Identify ways to reduce delays and improve transfer times
  - ✓Assist local jurisdictions in developing processes and sustainable goals to reduce the incidence of ambulance patient offload delays

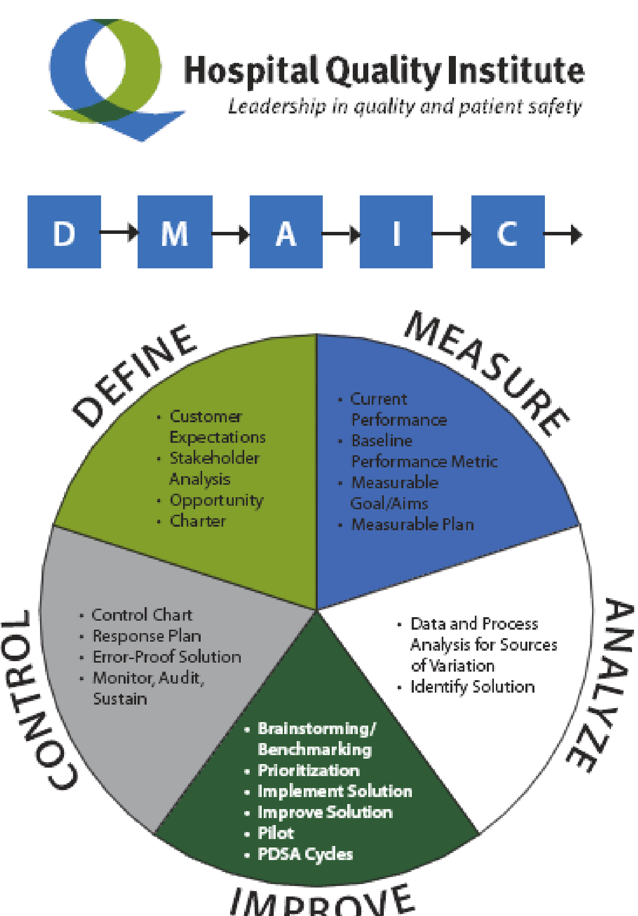
Web link: http://www.calhospital.org/cha-news-article/cha-releases-toolkit-reduce-ambulance-patient-offload-delays

Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department

Building Strategies for California Hospitals and Local Emergency Services Agencies

Quality Improvement Approach

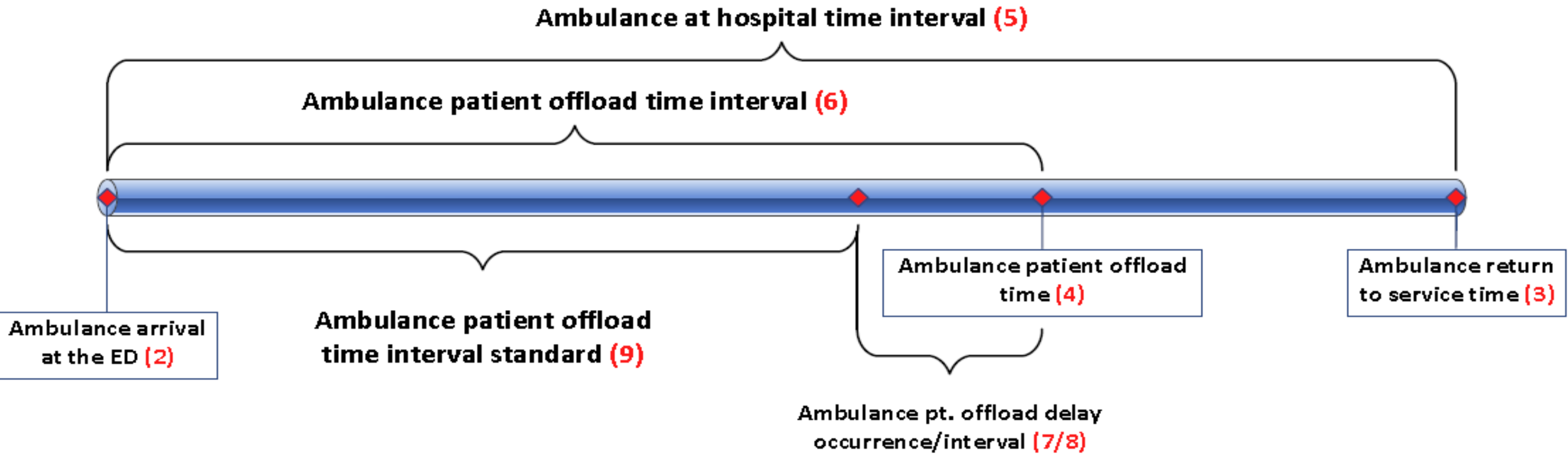
- Develop a collaborative structure for learning and action
- Combine subject matter experts
- Define, measure, analyze, improve and control
- Reflect and share lessons learned and best practices
- www.hqinstitute.org



Metrics

- Workgroup Objectives
  - Define the series of events in the EMS patient offload timeline.
  - Establish standardized definitions and nomenclature.
  - Define a data set across the timeline.
  - Identify “control” metrics.
  - Identify where time interval standards must be included for process improvement.
  - Identify current data collection methodologies.
  - Provide recommendations for data collection and reporting.

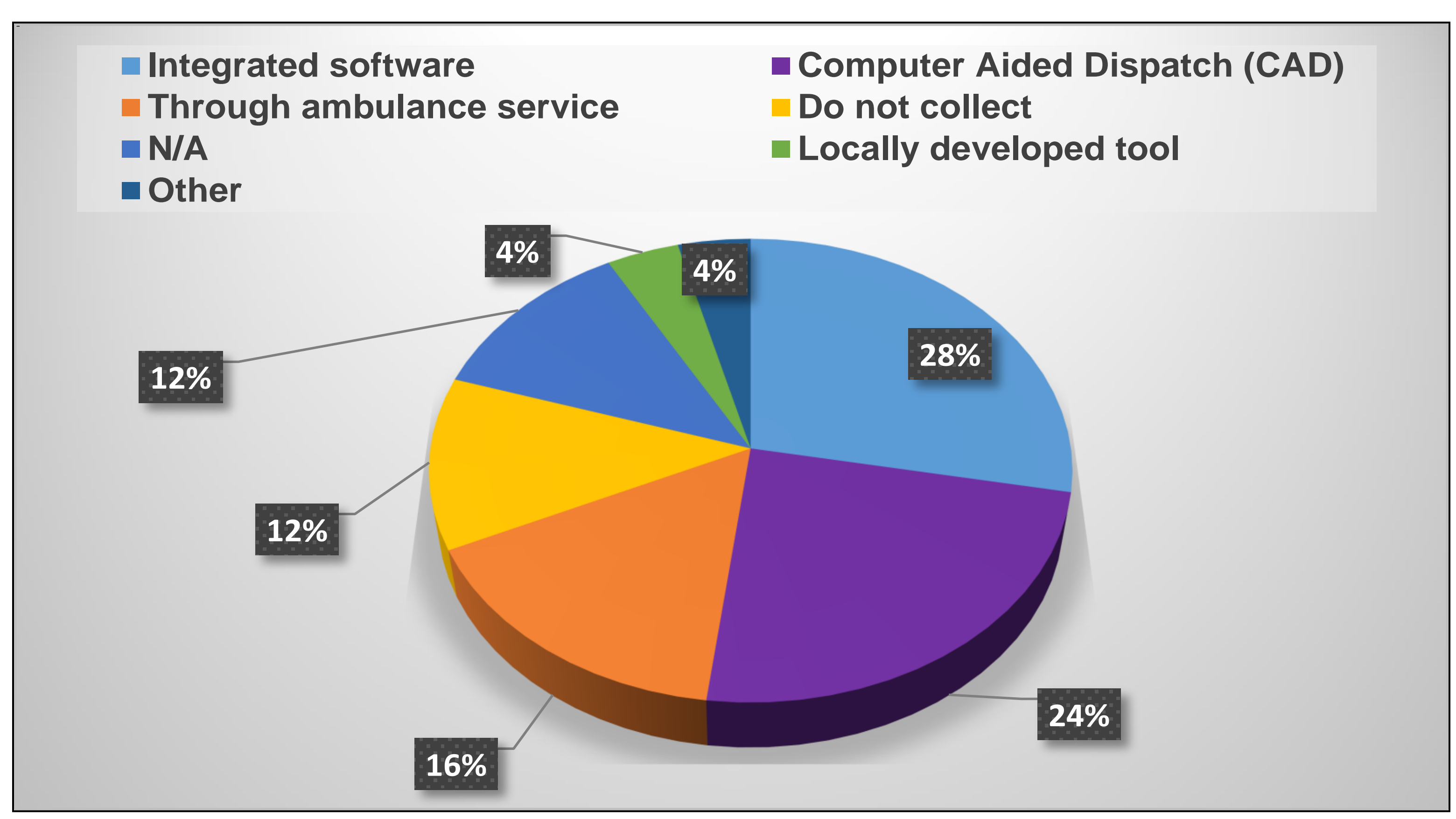
Metrics



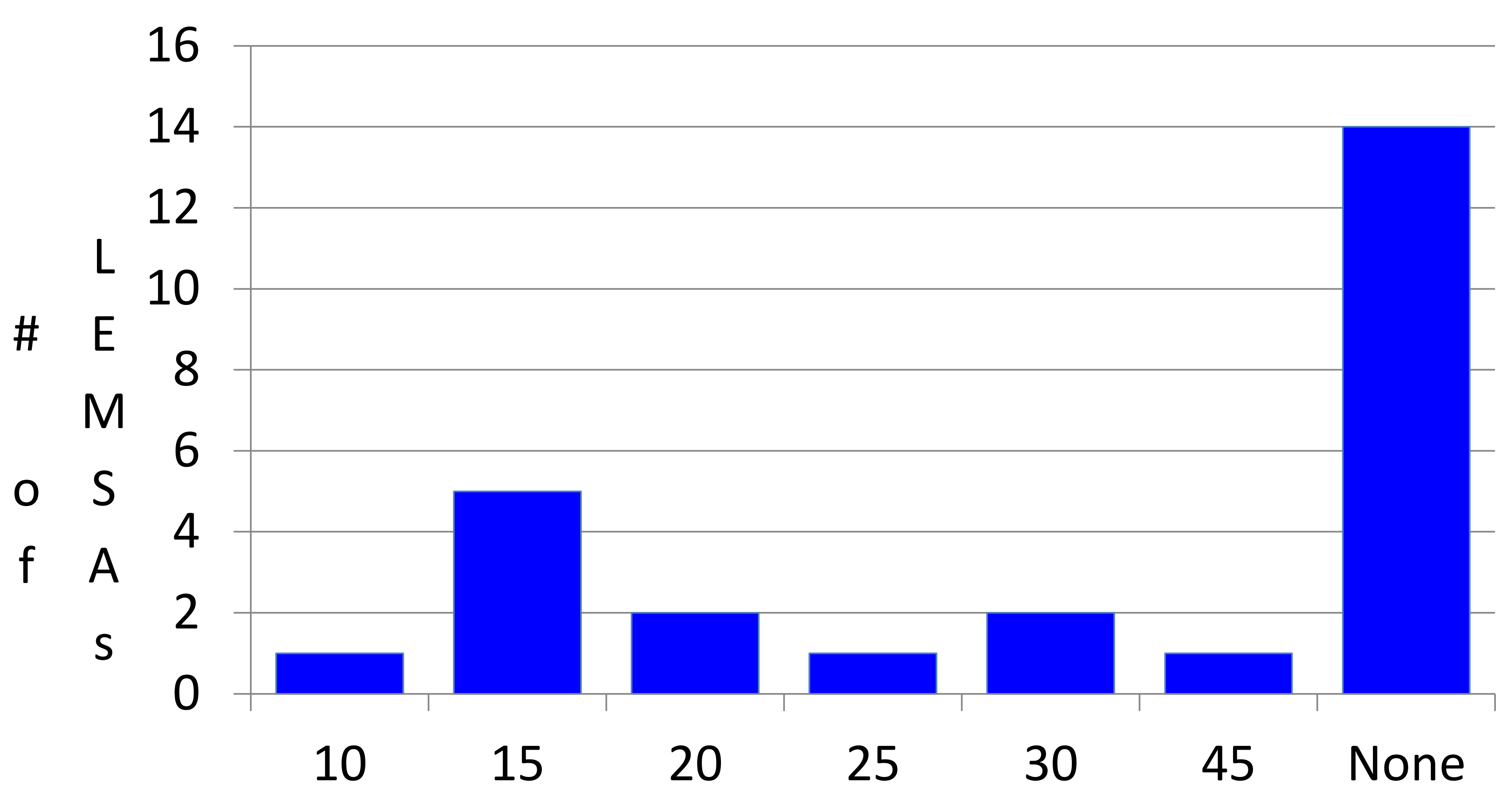
1. **Ambulance transport** – is defined as the transport of a patient from the prehospital EMS system by emergency ambulance to an approved EMS receiving hospital
2. **Ambulance arrival at the ED** - is defined as the time ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.
3. **Ambulance return to service time** – is defined as the time the ambulance is response ready after transporting a patient to a hospital ED.
4. **Ambulance patient offload time** – is defined as the time the patient is physically removed from the ambulance gurney to hospital equipment.
5. **Ambulance at hospital time interval** – defined as the period of time between ambulance arrival at the hospital ED and ambulance return to service time.
6. **Ambulance patient offload time interval** (commonly referred to as ambulance wait time or wall time) – is defined as the period of time between ambulance arrival at the ED and ambulance patient offload time.
7. **Ambulance patent offload delay interval** – is the resulting period of time produced when the ambulance patient offload time interval exceeds the established ambulance patient offload time interval standard. That is to say it is the time accumulated when a patient remains on the ambulance gurney in excess of the offload time interval standard.
8. **Ambulance patient offload delay occurrence –** the occurrence of an ambulance patient remaining on the ambulance gurney beyond the ambulance patient offload time interval standard.
9. **Ambulance patient offload time interval standard** – is the established system performance standard for the period of time between ambulance arrival at the ED and ambulance patient offload time.

LEMSA Data Collection Methods

Integrated software and Computer Aided Dispatch (CAD) are the top two methods LEMSAs collect data



LEMSA Survey: Off-load delay time standard (min)



Metrics

- Recommendations
  - APOD should be measured as a key indicator of EMS system function.
  - Standardized definitions and nomenclature should be adopted.
  - Process analysis, reporting and performance improvement should be a collaborative effort.
  - EMS systems should establish an ambulance patient offload standard between 15-30 minutes reported in terms of fractal compliance (facility and system).
  - EMS systems should define “sentinel events” and associated reporting processes.

Legal Considerations

- Paramedic scope of practice
- EMTALA
- Definition of “triage” and “medical screening”
- How does CMS/CDPH address EMS delays in transfer?
- What are the TJC standards on ED and hospital throughput?

Paramedics Scope of Practice

HSC 1797.52

Paramedics may practice…

while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

Does *not* provide for routine or extended continuation of care

Emergency Medical Treatment and Labor Act (EMTALA)

- Obligations triggered when individual presents to an emergency department seeking care or on hospital property (includes arrival by EMS).
- Requires initial assessment and triage "immediately on arrival…"
- Does not specifically define transfer of responsibility or formal acceptance of patient

EMTALA (2)

- Triage is the initial screening of the patient's presenting complaint to determine the appropriate order for the patient to receive a medical screening exam.
- Medical Screening Exam (MSE) is the evaluation of presenting condition of patient to determine if an emergency medical condition exists.
- No prescribed process or timeframe

CMS, S&C-06-21 (July 2006)

Parking patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability to provide emergency services to the rest of the community…

This practice may result in a violation of the EMTALA and raises serious concerns for patient care…Additionally, this practice may also result in violation of the Conditions of Participation for Hospitals…

(CMS) S&C-07-20, April 2007

S&C 06-21 does not mean that "a hospital will not necessarily have violated EMTALA if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED ... In some circumstances it could be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual."

CDPH AFL 07-04

There needs to be a different solution to this problem [ED crowding] as parking patient in hospitals and refusing to release EMS equipment or personnel puts patients health at risk and jeopardizes the ability of the EMS staff to provide their important services to California communities.

CMS State Operations Manual, Appendix V

- Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins.
- Hospitals that park patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospital meet the emergency needs of patients…

EMTALA Violation

- CMS has not established a maximum acceptable time for transfer of responsibility from EMS to ED staff
- Review 10/31/2014: deficiency cited Fed-A-2406-489.24(r) and (c) Medical Screening Exam for two patients
- Waiver only for 72 hrs during an emergency

Policy vs Reality

- Policy: Triage consists of a brief assessment that determines the level of acuity. This will include HPI, exam, PMH, meds, allergies, complete vitals
- Reality: Brief report to triage nurse on arrival but no staff assessment.
- Charge nurse visually looks at the patient “quick look across the way” and asks EMS for vital signs
- Nurses would glance at the patient as they went by and rely on EMS to tell them if change in status

CCR Title 22 Section 70129

Requirements do not prohibit the use of alternate concepts, methods, procedures, techniques…or the conducting of pilot projects… with the provisions for safe and adequate care and with the written approval of the Department

Potential Means to Address Transfer Delays

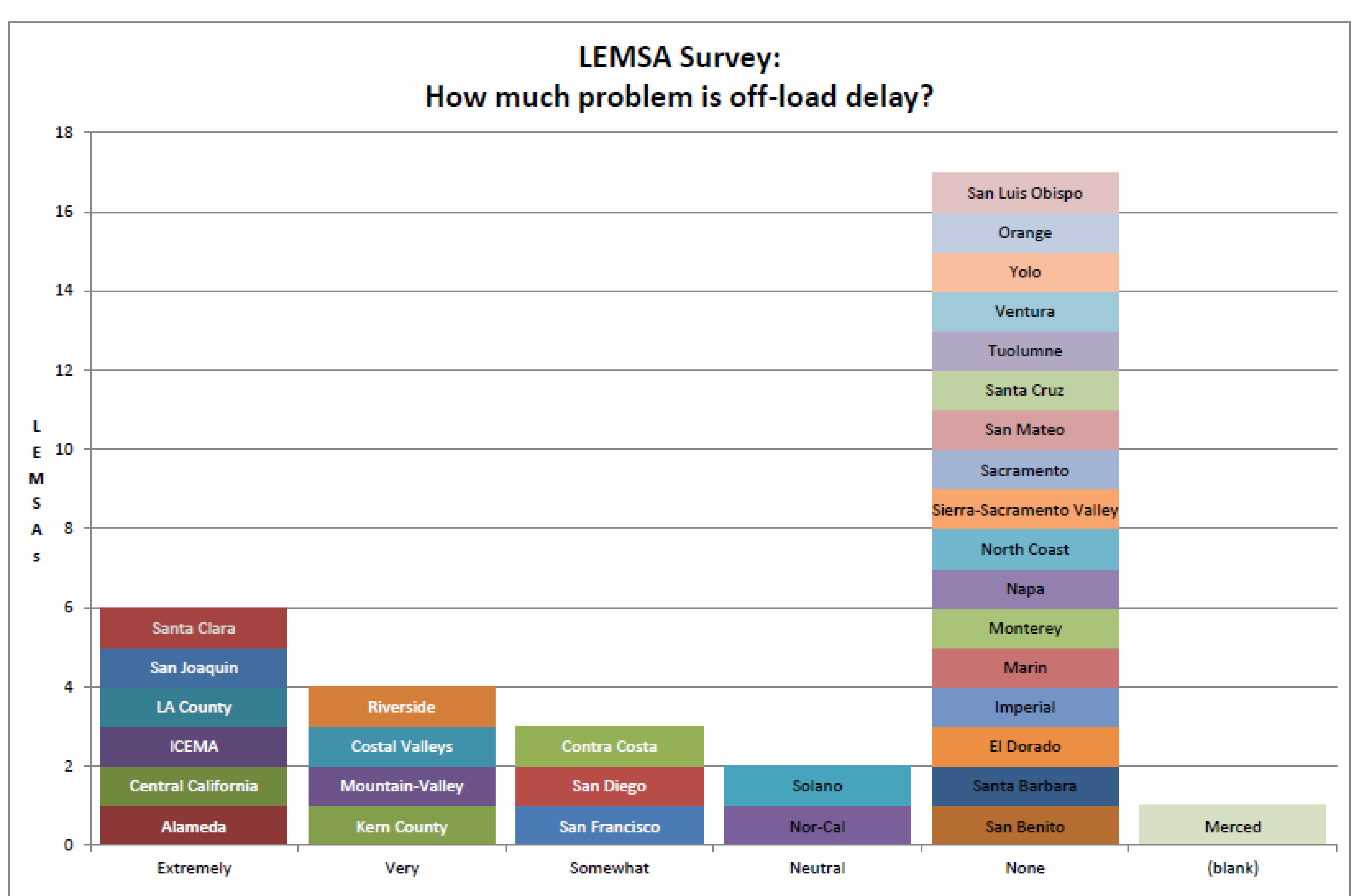
- Quality Improvement process
- Joint Commission: ED throughput
- Contractual obligations
- EMTALA
- Regulatory standards
- Statutory standards

The Joint Commission accreditation standard for ED Patient Flow (LD.04.03.11)

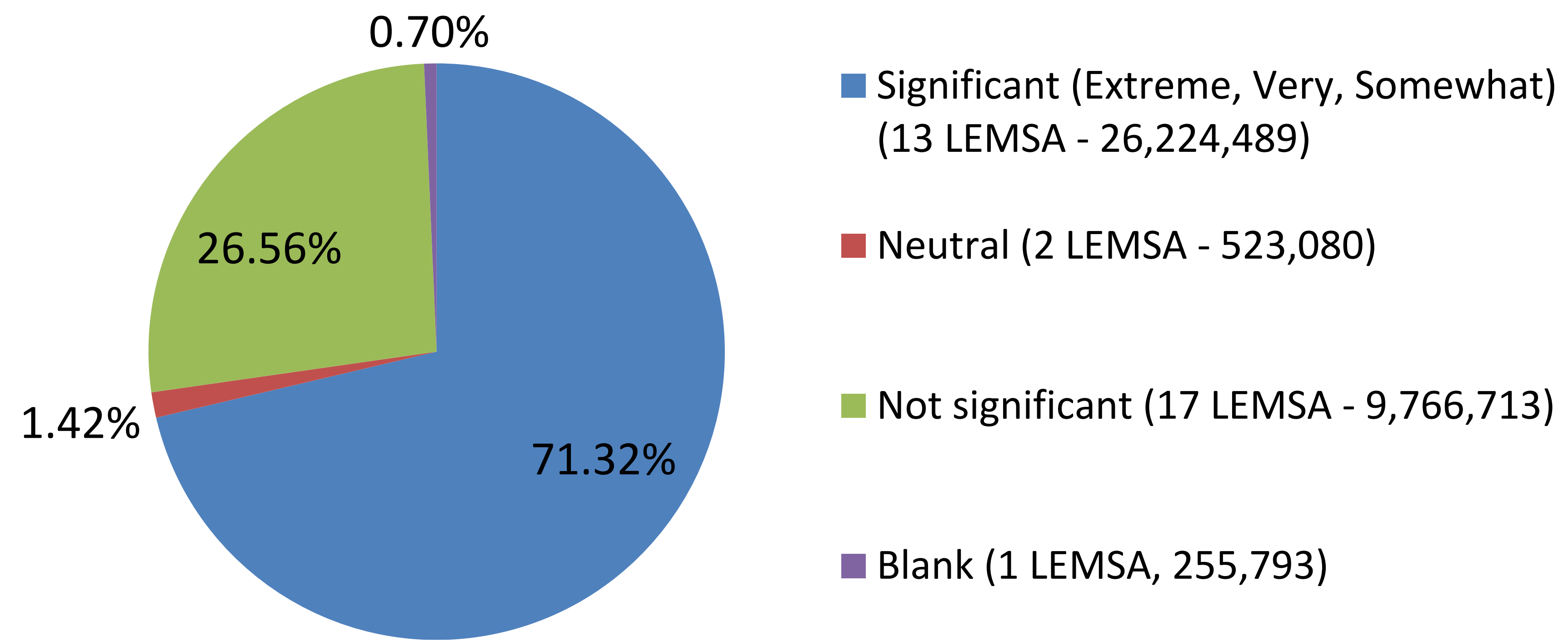
- Went into effect January 2, 2014
- Nine elements of performance
- Recommended that "boarding time frames not exceed four hours in the interest of patient safety and quality of care"
- The individuals who manage patient flow processes review measurement results to determine that goals were achieved
- Leaders take action to improve patient flow processes when goals are not achieved

Survey Findings

Severity of Offload Delay by LEMSA

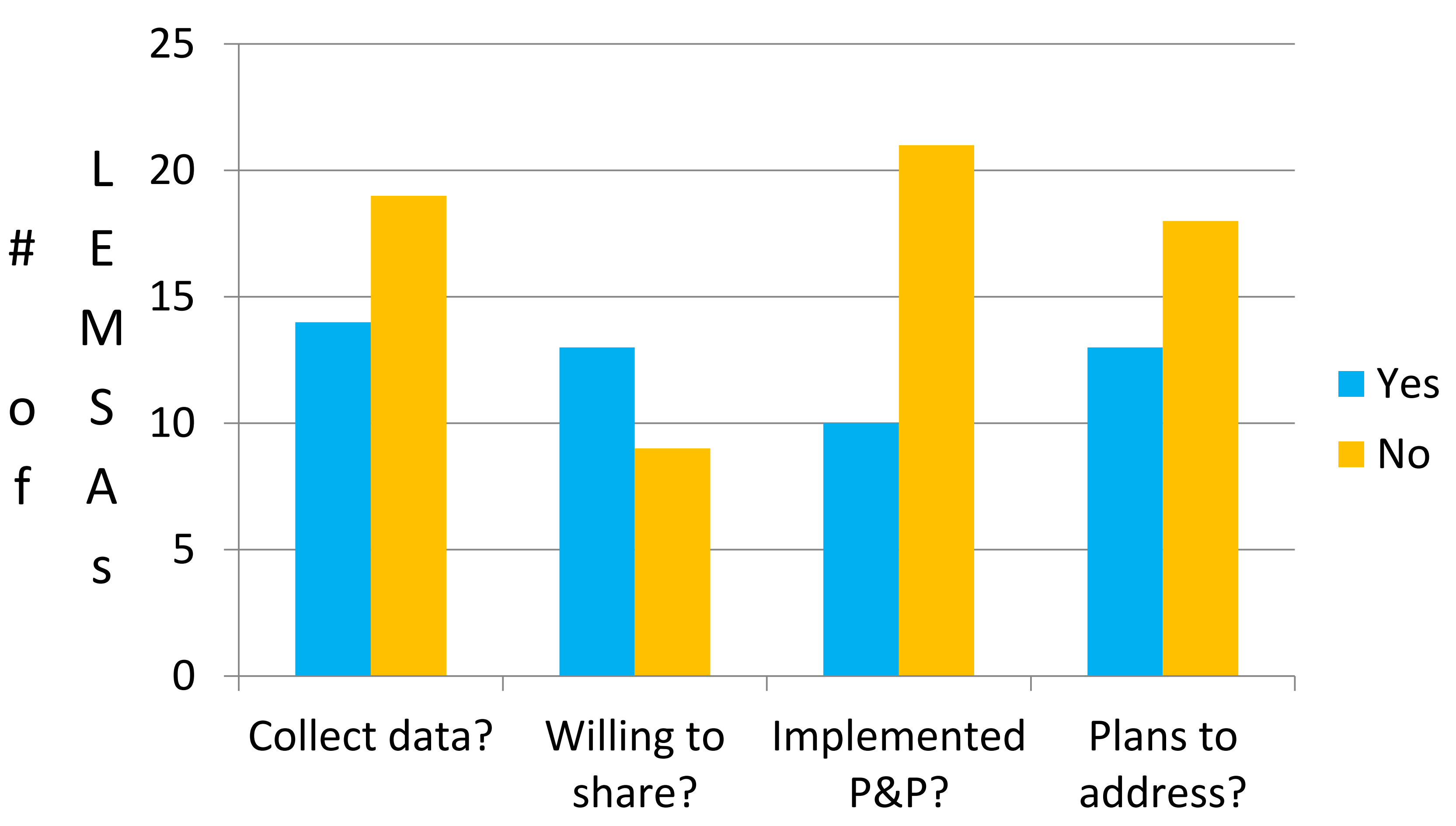


Percentage of CA Population (2010) in LEMSA Boundry with an Off-Load Delay Problem Based on 2013 EMSAAC Survey



Response	Sum of Population	Response Count
Extremely significant	17540255	6
Somewhat significant	4949573	3
Very significant	3734661	4
Neutral	523080	2
Not significant	9766713	17
(blank)	255793	1
Grand Total	**36770075**	**33**

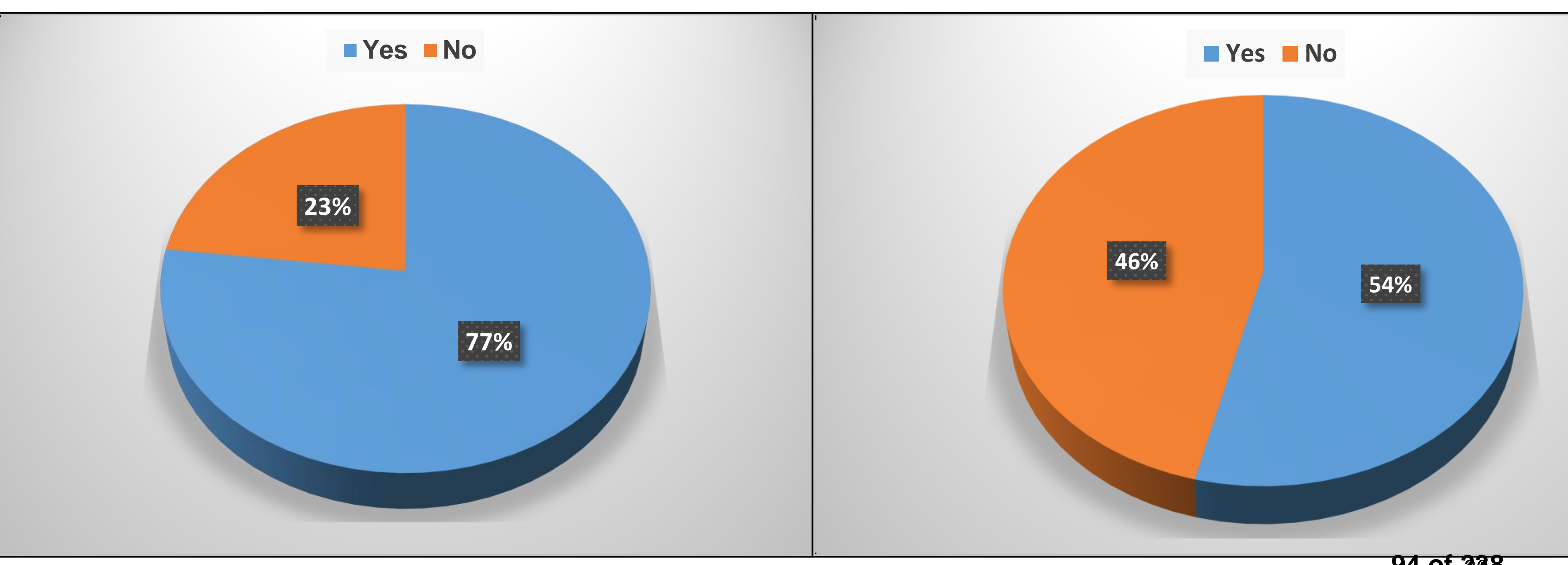
Off-load Delay LEMSA Survey



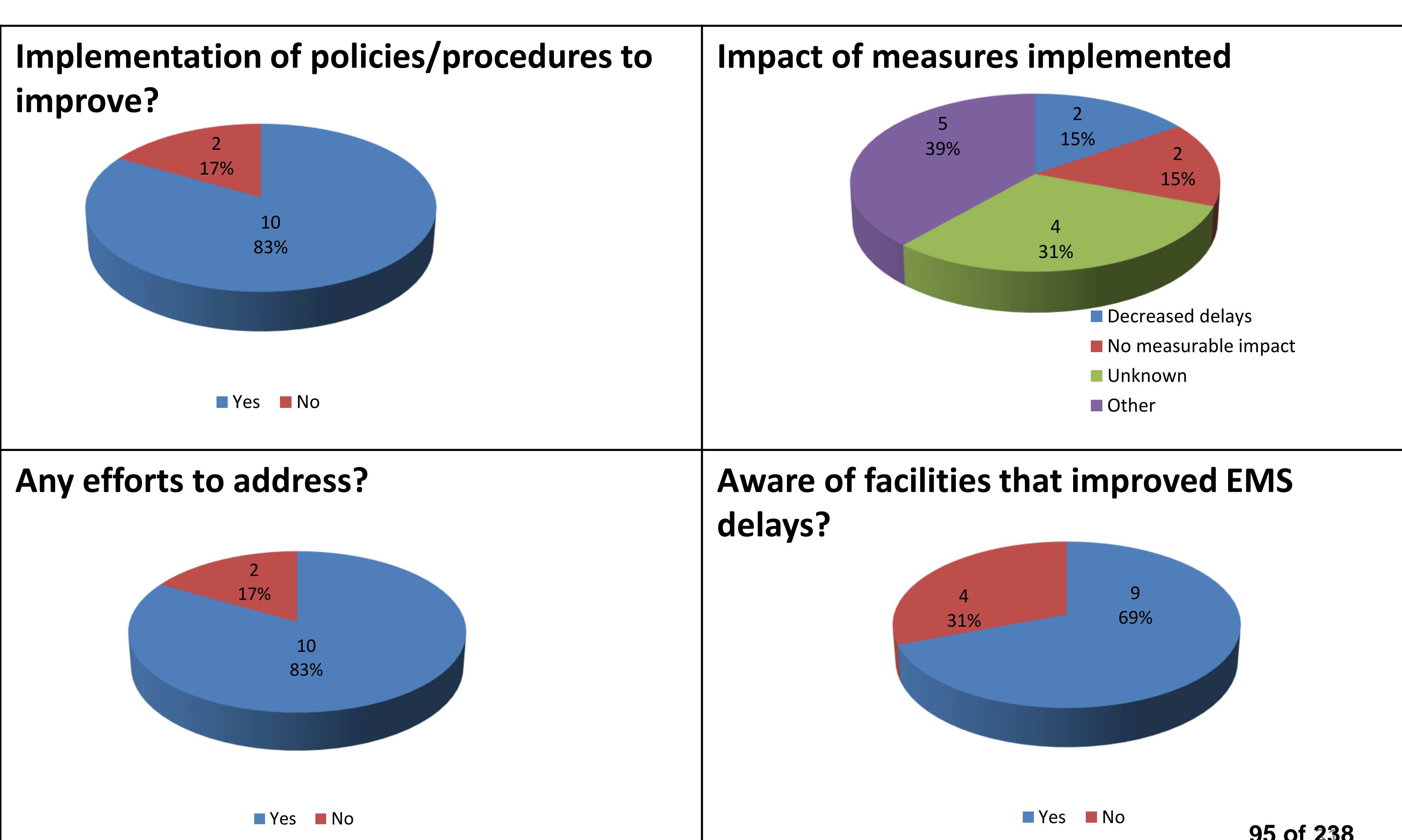
LEMSA Survey Observations: Collection and Reporting of Data

13 LEMSA agencies that reported a significant problem

- A majority (77%) do collect EMS offload time interval data
- Only a little over half (54%) actually report the data



LEMSA Reported Efforts to Address Problem (13 LEMSAs that reported significant problem)



Consensus on Offload Delays

Both LEMSAs and hospitals showed consensus on issues with offload delays except for Coastal Valley and Mountain Valley counties where hospitals reported offload delays "not significant" and LEMSA reported "very significant."

Hospital Respondents Grouped by LEMSA Region

Respondents by Region That Report "Very Significant" or "Extremely Significant" Impacts of Offload Delays	Count	Percent
Los Angeles	10	31.3%
ICEMA	5	15.6%
Riverside	5	15.6%
Alameda	2	6.3%
Kern	2	6.3%
Central California	1	3.1%
Contra Costa	1	3.1%
Merced	1	3.1%
Orange	1	3.1%
Sacramento	1	3.1%
San Joaquin	1	3.1%
Santa Clara	1	3.1%
Sierra-Sacramento Valley	1	3.1%
Coastal Valley	0	0.0%
Imperial	0	0.0%
Marin	0	0.0%
Monterey	0	0.0%
Mountain Valley	0	0.0%
North Coast	0	0.0%
Northern California	0	0.0%
San Diego	0	0.0%
San Francisco	0	0.0%
San Mateo	0	0.0%
Santa Barbara	0	0.0%
Solano	0	0.0%
Tuolumne	0	0.0%
Ventura	0	0.0%
Yolo	0	0.0%
Total	32	100.0%

Respondents by LEMSA That Report "Neutral" or "Not Significant" Impact of Offload Delays	Count	Percent
Los Angeles	15	20.3%
San Diego	7	9.5%
Sierra-Sacramento Valley	6	8.1%
Orange	5	6.8%
Kern	4	5.4%
Coastal Valley	3	4.1%
ICEMA	3	4.1%
Santa Barbara	3	4.1%
Solano	3	4.1%
Ventura	3	4.1%
Contra Costa	2	2.7%
Monterey	2	2.7%
Mountain Valley	2	2.7%
Riverside	2	2.7%
San Mateo	2	2.7%
Yolo	2	2.7%
Alameda	1	1.4%
Central California	1	1.4%
Imperial	1	1.4%
North Coast	1	1.4%
Northern California	1	1.4%
Sacramento	1	1.4%
San Francisco	1	1.4%
San Joaquin	1	1.4%
Santa Clara	1	1.4%
Tuolumne	1	1.4%
Marin	0	0.0%
Merced	0	0.0%
Total	74	100.0%

10 LEMSAs reporting significant delays

Hospital Offload Mitigation Strategies: Summary

CALIFORNIA HOSPITAL ASSOCIATION

- ED Intake was the strategy that had the highest frequency of being implemented
- Conversely, the topic with the least frequency of being implemented was ED Output

Mitigation Strategy Implemented Topics	Count
ED Intake	460
ED Throughput	250
ED Output	105
ED Overall	317
Hospital Inpatient	240
Hospital Overall	240

Similar mitigation strategies are used by hospitals with and without issues

ED Intake Mitigation Strategy	32 Hospitals With Issue	%	74 Hospitals Without Issue	%
Bedside registration	26	81%	58	78%
Orders from triage	24	75%	57	77%
Accelerated intake processes	24	75%	53	72%
"Direct to bed" policy	23	72%	55	74%
Mid-level or physician provider at triage	18	56%	25	34%
Greeter / patient liaison	15	47%	25	34%

Four of the six intake strategies were implemented by approximately 80 percent of both sets of hospital groups.

ED Throughput Mitigation Strategy	32 Hospitals With Issue	%	74 Hospitals Without Issue	%
Effective ordering of lab and imaging	26	81%	56	76%
Innovating staffing utilization	25	78%	51	69%
Hospital Code Alert for ED overcrowding	16	50%	39	53%

Top 2 efforts to address delay via ED throuput were implemented by 81 percent of hospitals with an issue and 73 percent of hospitals without an issue.

ED Output Mitigation Strategy	32 Hospitals With Issue	%	74 Hospitals Without Issue	%
Accelerated inpatient intake practices	17	53%	34	46%
Discharge czar/accelerator	10	31%	11	15%
Use of Clinical Decision Unit (CDU)	5	16%	12	16%
Discharge instructions upon arrival	1	3%	1	1%

The top output strategy "accelerated inpatient intake practices" was implemented by 53 percent of hospitals with an issue and only 46 percent of hospitals without an issue.

ED Overall Mitigation Strategy	32 Hospitals With Issue	%	74 Hospitals Without Issue	%
Management of ED throughput metrics	28	88%	67	91%
ED management "rounding"	25	78%	56	76%
Charge ED physician-nurse concept (shift leaders)	22	69%	51	69%
Use pharmacist in ED	10	31%	16	22%

The top overall ED strategy "management of ED throughput metrics" was implemented by 88 percent of hospitals with an issue and 91 percent of hospitals without an issue, a clear priority for both.

Mitigation factors that work for hospitals with no offload delays

CALIFORNIA HOSPITAL ASSOCIATION

For hospitals with Neutral + Not Significant EMS offload delays, what factors would you attribute to this? Check all that apply.	Count	Percent
Optimized ED intake process	37	23%
Successful hospital process improvement measures	34	21%
Hospital and local EMS agency collaborate and have ongoing patient improvement measures	23	14%
No historical problem on this subject	27	17%
Other (please specify)	30	19%
Physical plant redesign	9	6%
Total	160	100%
Hospital Count	74	-

Examples of hospital process improvement measures

Improvement Measure	Count	Percent
Hospital administration awareness/Entire hospital involved/Inpatient bed control/New processes/Float RN assigned to hall patients	11	37%
EMS arrivals get a bed immediately even if it means using wheelchairs, triage and hallway beds	7	23%
Working with providers	5	17%
Other: Impacts our psych ED/Pediatric specific/High wall time because of walk-ins, BLS & ALS patients	3	10%
Work with EMS agency	2	7%
Identified what other hospitals have done to reduce offload times	1	3%
Built a bigger ED	1	3%
Total	30	100%

Solutions

- Hospital throughput initiatives
  - CHA's Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department
  - Intake measures most commonly deployed
  - Output measures least implemented - Focus on causes for, for ie. decreased inpatient capacity & lack of post acute placement issues
  - ED Behavioral Health Tool kit , CHA Behavioral Health Symposium

Learning Laboratories

- Santa Clara
- Riverside/San Bernardino
- Los Angeles
- Contra Costa

Learning Laboratories

- Santa Clara
- Riverside
  San Bernardino
- Los Angeles
- Contra Costa

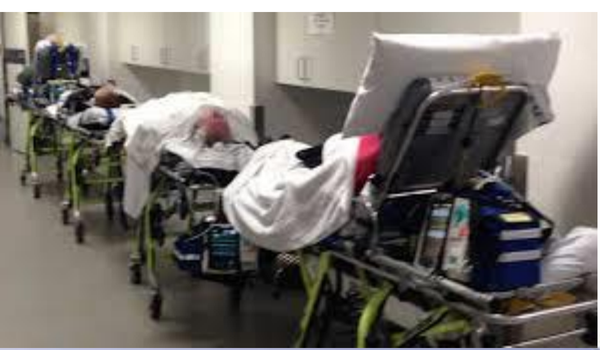
The impact of ED closure

What if your child was found face down in a pool

And the closest ED looked like this…

Purpose

- To achieve a greater understanding of what closure and wall-time means to our community and how you can have an impact



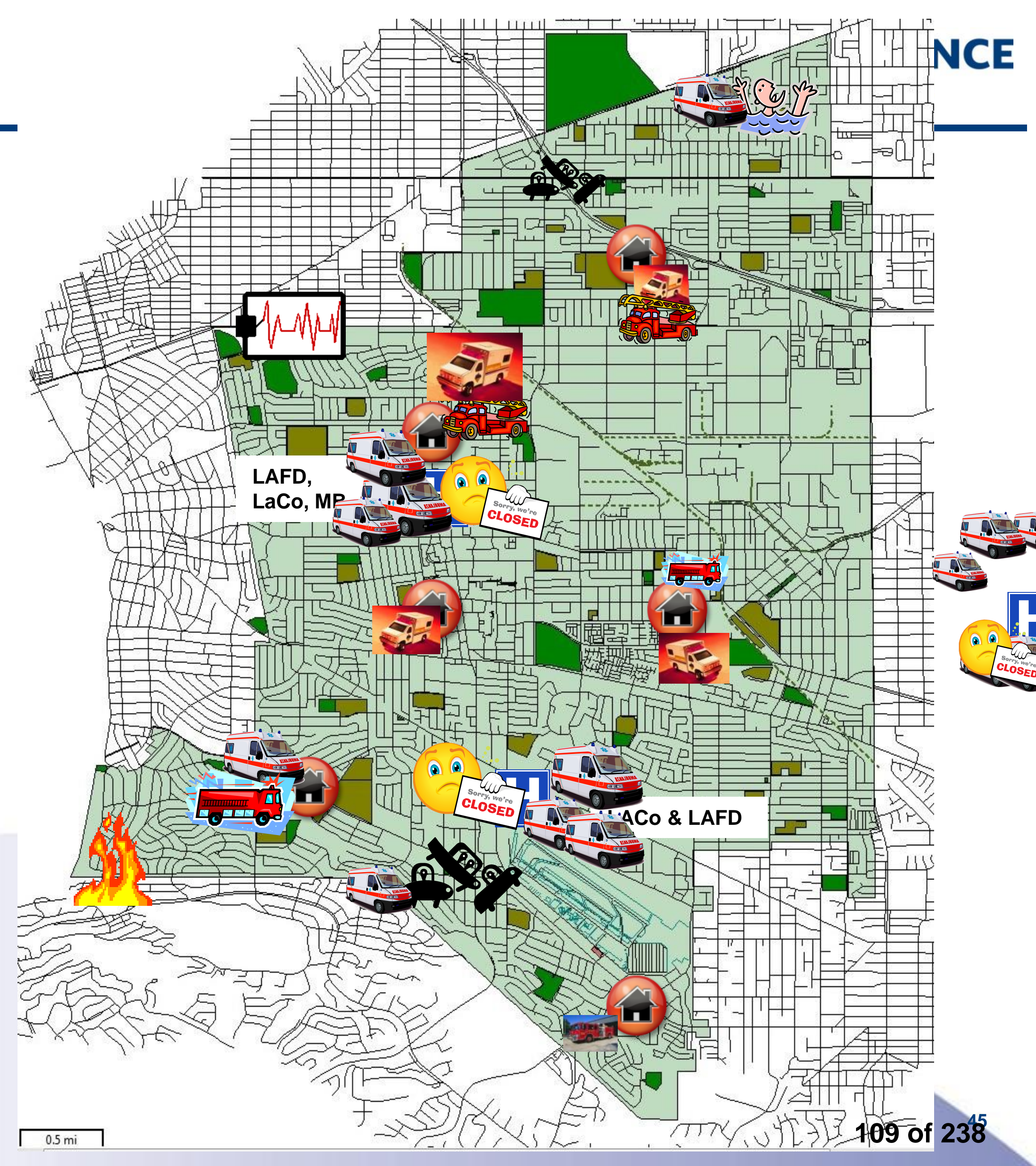
Definitions

- ED Closure:
  - ED is saturated and we are notifying EMS that we cannot safely care for any more critical patients. However….
    - BLS runs will still arrive
    - Patients in extremis will still arrive
    - Code Strokes and Code AMIs will still arrive
    - Patients will still walk in to triage
- Wall Time:
  - Time the Paramedic waits at the "wall" for a bed to open up to transfer care to the ED staff
  - LAFD estimates the equivalent of 4 ambulances out of service each day due to "wall time"

Why do we want to stay open?

- When the ED closes, we are effectively closing off services for the very community the Sisters of Providence built this facility to serve
- Our community has to go elsewhere for care
- When the ED closes it impacts all EMS services, not just healthcare…..

Let's go through a typical scenario of a weekday afternoon around 5pm



City of Torrance Fire Stations

It is about keeping our ED open and **all** Emergency Medical Services available to serve our community.

WHAT CAN YOU DO TO MAKE A DIFFERENCE?

The Challenge

- We want to challenge the managers to:
  - Review discharge order times for the next 2 weeks
    - Do you go back and review the discharges and see what you can do to facilitate?
  - We know that every afternoon the admits will come
    - How can you facilitate getting the inpatients out of the ED so the ED can treat the incoming emergencies?

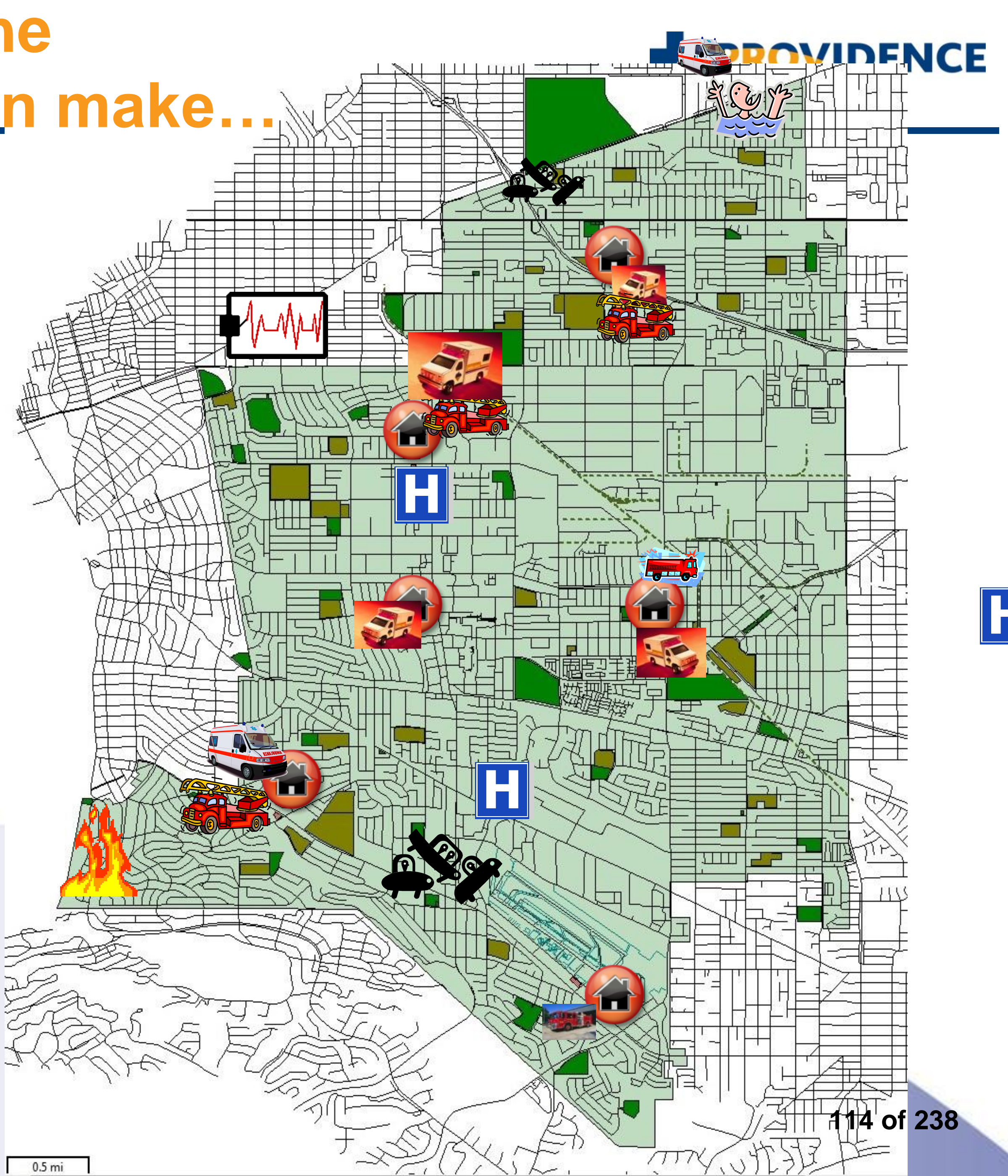
The Challenge

- Keep track of how long from discharge order to discharge time
  - Identify potential issues and solutions
  - Identify roadblocks
  - Can we look at a different staffing or assignment pattern?

Work that is Ongoing

- House-wide Throughput Kaizen Fall 2014
- Call to CNO if patient waiting more than 3 hours (post Admit order) in ED
- Several Green-Belt activities
  - “Super” track
  - Front End / Triage
  - EMS Run arrival
    - Triage
    - EKGs
    - Hand-off

Because this is the difference you can make…



Total run time
10 min door to door

which scenario would you want if this was your child??

Contra Costa EMS
Patient Transfer of Care (TOC)
A Patient Centric Model

Patricia Frost RN, MS, PNP
Director Contra Costa Emergency Services
EMSA/ California Hospital Association
Wall Time Collaborative Meeting February 9, 2015

Contra Costa County EMS System

- 1.1 Million Population
- No ED Diversion County since 2006
- Hospital reporting of offload times since 2008
- 9 Hospitals (8 Basic and 1 Standby)
- 65,000 transports per year
- Over 6,200 delays per year
- Everyday 10% of 911 patients experience transfer of care delays
- Encourage Hospital Use of NEDOCs

Hospital Capacity and EMS Transfer of Care

County Wide Emergency Department Capacity and Utilization	ED BEDS	OSHPD TOTAL REPORTED ED VISITS 2013	OSHPD ED VOLUME PER ED BED 2013[2]	TOTAL EMS TRANSPORTS 2013 (All Contra Costa County Transports)[3]	PERCENT OF EMS TRANSPORTS BY TOTAL ED VISITS 2013	DAILY AVERAGE 2013 (All Contra Costa EMS Transports)
Contra Costa Regional Medical Center[4]	20	58,677	2934	10,829	18%	29.7
Doctors Medical Center	25	40,384	1615	8,053	20%	22.1
John Muir-CONCORD	32	50,565	1580	8,119	16%	22.2
John Muir-WALNUT CREEK	47	45,663	972	8,684	19%	23.8
KAISER ANTIOCH	34	42,845	1260	5,003	12%	13.7
KAISER RICHMOND	15	40,065	2671	5,161	13%	14.1
KAISER WALNUT CREEK	52	54,228	1043	7,231	13%	19.8
SAN RAMON REGIONAL	12	16,909	1409	2,181	13%	6.0
SUTTER DELTA	32	51,748	1617	8,142	16%	22.3
TOTAL	269	401,084	1491	63,403	16%	173.7

Current EMS System Performance Expectation

Contra Costa Emergency Medical Services (EMS) System Performance Expectation

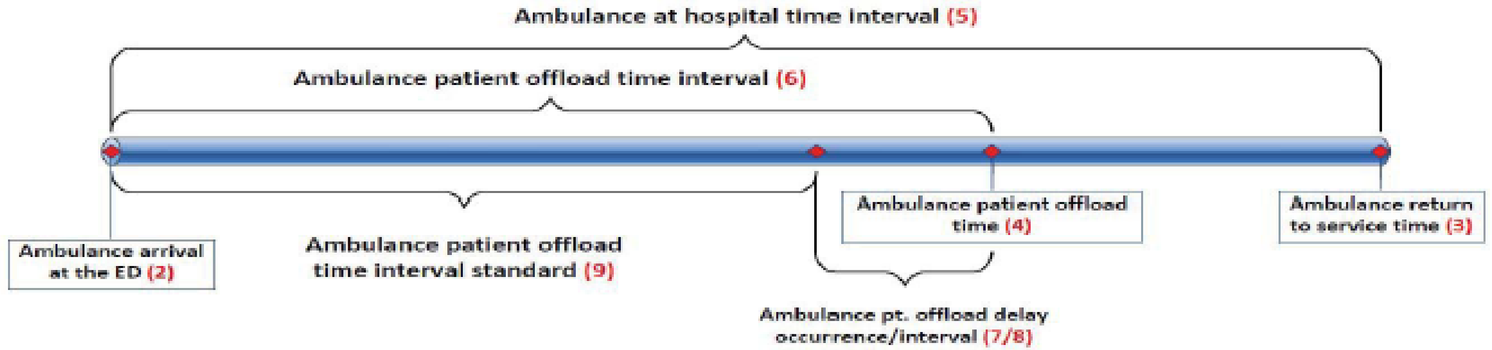
EMS Policy #40: Hospitals designated as an EMS receiving facility in Contra Costa County shall be prepared to receive patients transported by 9-1-1 county ambulance providers and accept these patients upon arrival. The patient transfer of care performance expectation for the EMS System is 20 minute or less; 90% of the time.

Countywide Hospital Performance (Nov 2013 to Oct 2014)

90th Percentile of All Facilities[1]
Patient Transfer of Care occurs between 18 to 21 minutes 9 out of 10 times

Description of Patient Transfer of Care (TOC)

The California Hospital Association and the EMS Administrators of California have proposed the following graphic to describe the intervals associated with patient transfer of care. In Contra Costa County our metric of patient transfer of care or handoff time is equivalent to the ambulance patient offload time interval.



EMS Transfer of Care Standards (Policy 40)

http://cchealth.org/ems/pdf/policy40.pdf

- Hospitals designated as an EMS receiving facility in Contra Costa County shall be prepared to receive patients transported by 9-1-1 county ambulance providers and accept these patients upon arrival. The patient transfer of care performance expectation for the EMS System is 20 minutes or less 90% of the time.
- The EMS Agency shall routinely report Patient Transfer of Care times by hospital and the fiscal impact on the EMS system in reports posted for public review at www.cccems.org.
- Clearly defines what is expected and resolution process
- Never Events (TOC > 60 minutes) and mandates EMS Event Reporting

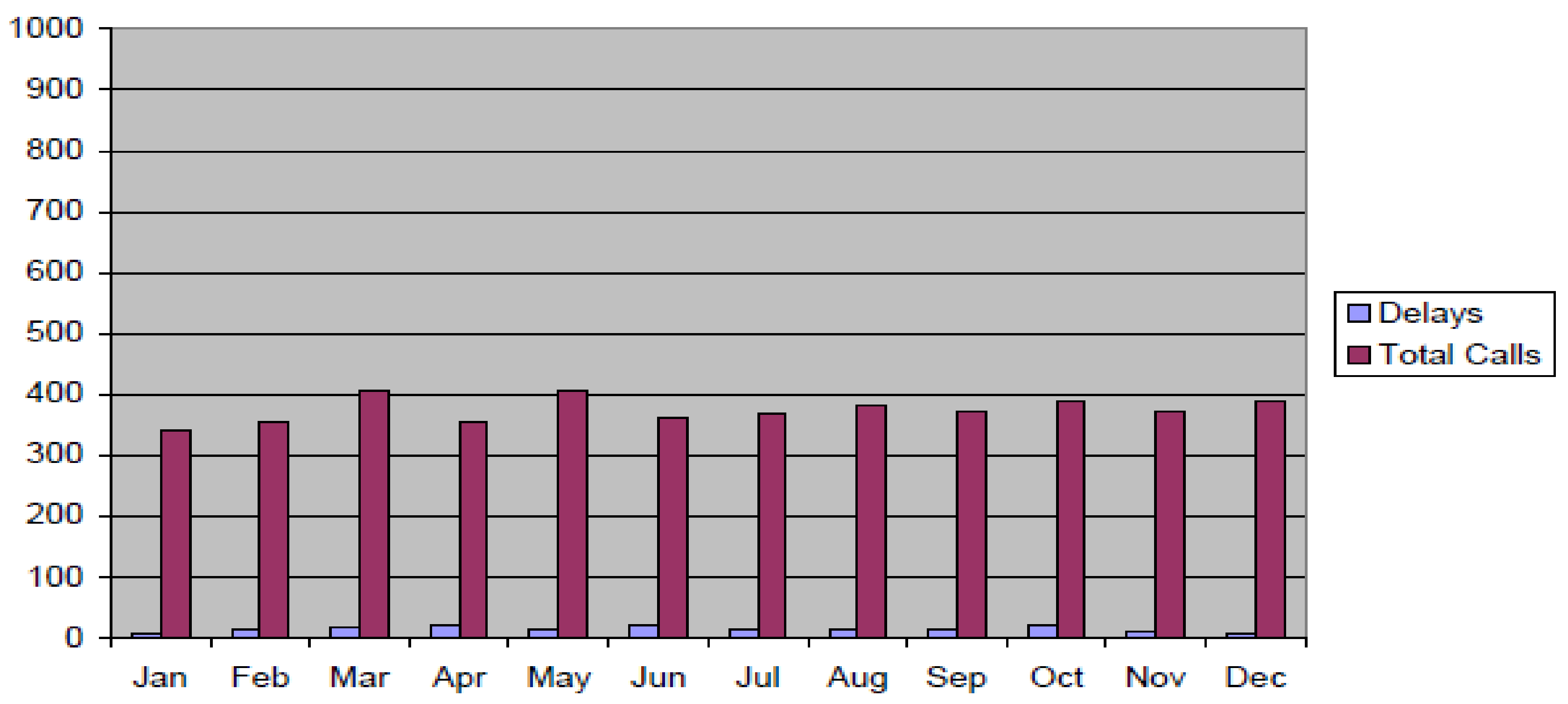
Defines Unusual Demand

*Periods of unanticipated high levels of Emergency Department demand that are unable to be addressed by internal protocols for emergency department saturation e.g. Multi-casualty Incidents or Hospital Internal Disaster. Unusual level of demand **does not** include predictable high utilization periods associated with normal EMS System operations e.g. seasonal flu, time of day or day of week.*

EMS Event Reporting Policy

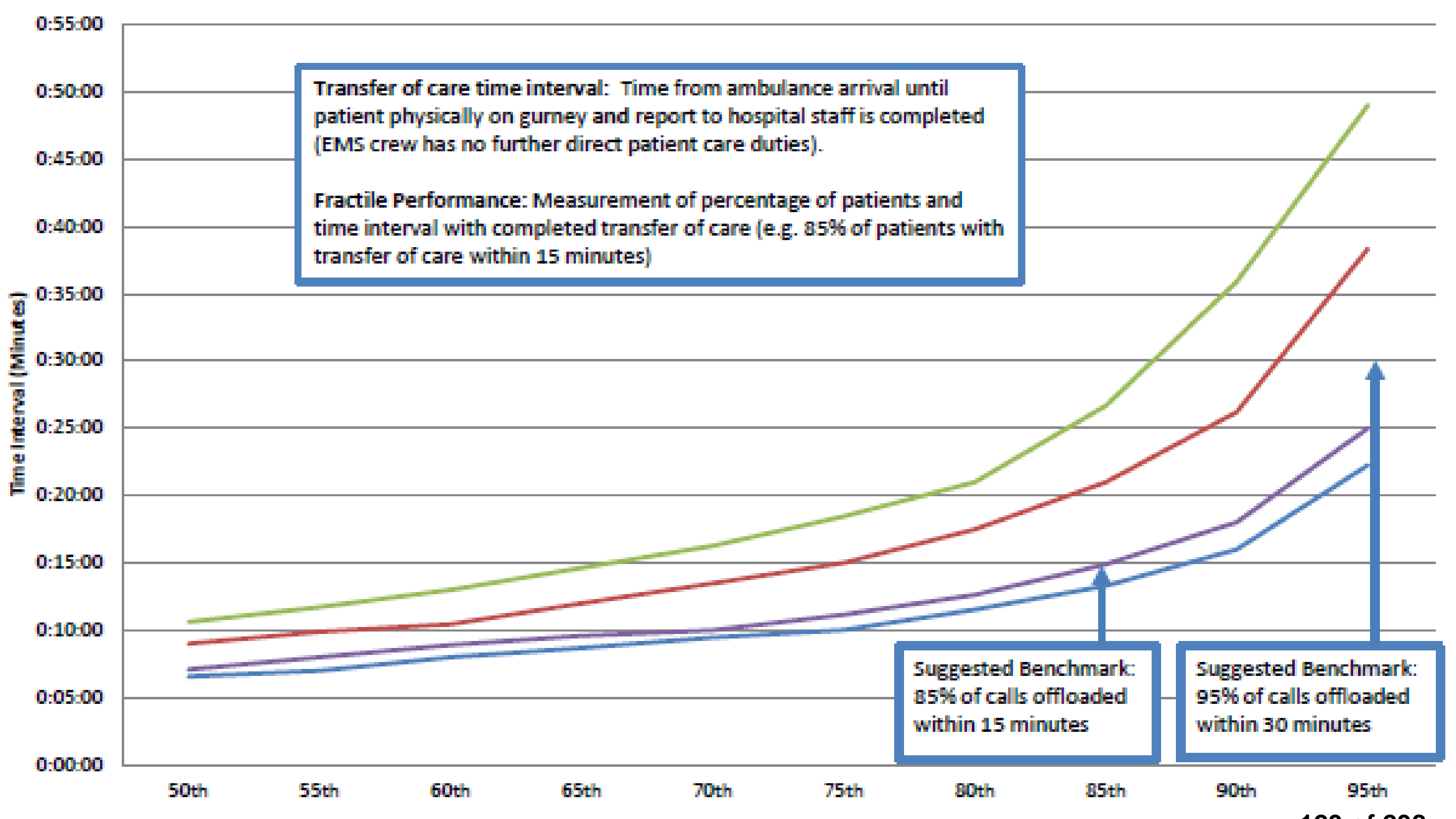
- Reporting supporting a culture of patient safety
- Every EMS event…an opportunity to improve
- EMS events shall be appropriately reported, reviewed and tracked to monitor, maintain and improve safety.
- Submitted to Hospital Quality

First Metric: > 45 minutes
Time of ambulance arrival till time available



EMS Systems are designed to produce predictable results

EMS/ED Workflow
Rely on the data & benchmark



Current Report 9 out of 10 Transports < 21 minutes

Patient Handoff Times by Facility
90th PERCENTILE OF ALL FACILITIES
November 2013 - October 2014
59,164 Transports (4,930 per Month)
Source: AMR MEDS (ePCR Database)

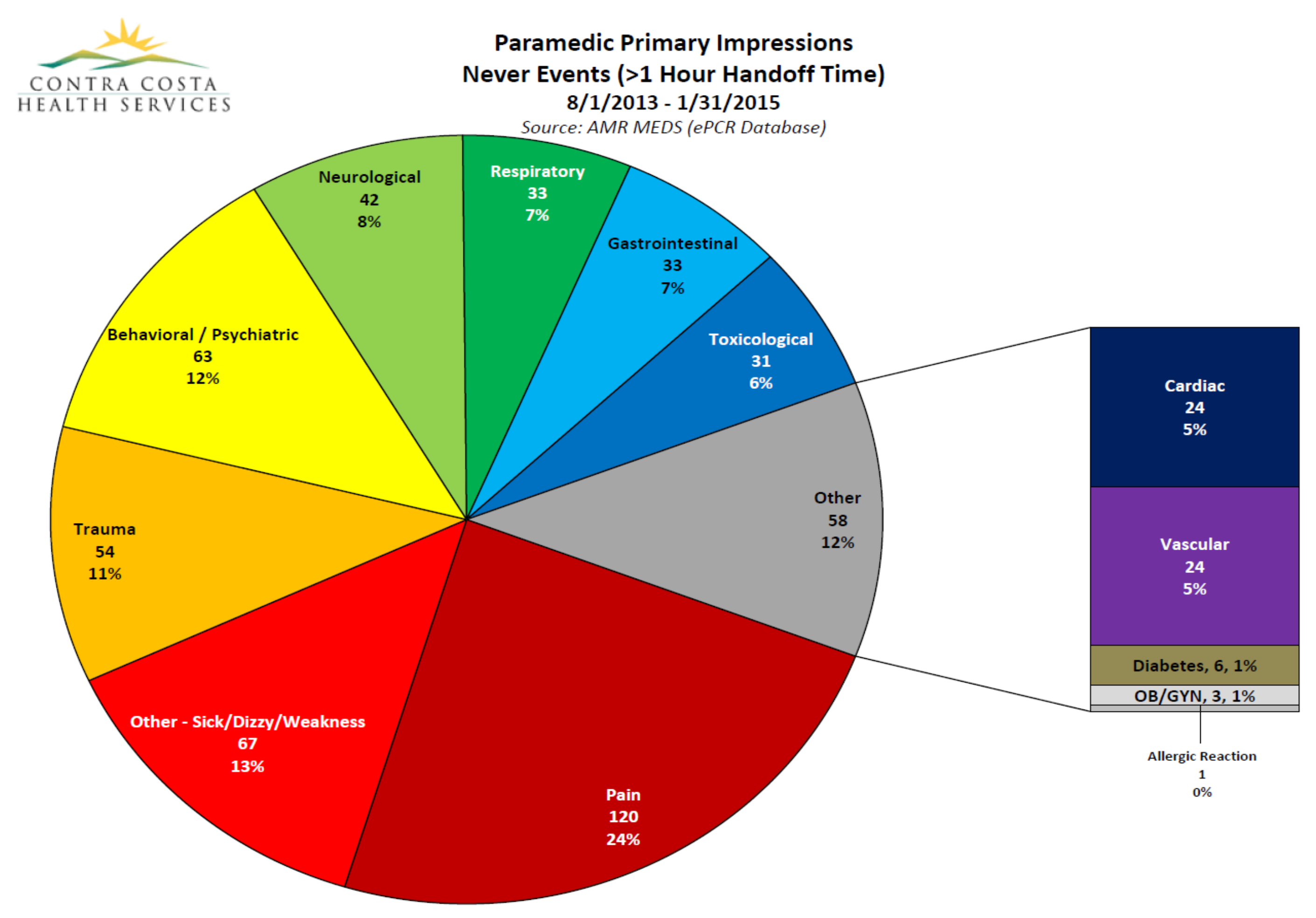
Month & AMR Transport Volume	90th Percentile
Nov '13 4,612	0:19:27
Dec '13 5,095	0:19:27
Jan '14 5,384	0:22:00
Feb '14 4,661	0:19:24
Mar '14 5,025	0:18:39
Apr '14 4,862	0:20:00
May '14 5,367	0:19:35
Jun '14 4,927	0:18:06
Jul '14 5,013	0:18:07
Aug '14 4,692	0:20:01
Sep '14 4,743	0:20:55
Oct '14 4,783	0:20:13

EMS Never Events (Patient Handoff > 1 hour)

Patient Safety Initiative: The Journey to Zero

Never Events by Facility (>1 Hour Drop Time)	2013 (8/1/2013 - 12/31/2013)	2014 (1/1/2014 - 12/31/2014)	2015 (1/1/2015- 1/31/2015)	*Grand Total*
CCRMC	2	15	6	***23***
CCRMC - PES	6	34	4	***44***
John Muir - Concord	8	19	1	***28***
John Muir - Walnut Creek	3	17	3	***23***
Kaiser - Antioch	4	10	2	***16***
Kaiser - Richmond	1	13	1	***15***
Kaiser - Walnut Creek	2	8	1	***11***
Sutter Delta	36	285	20	***341***

Which Patients Experience Never Events?



Never Event Characteristics: Affects All Ages

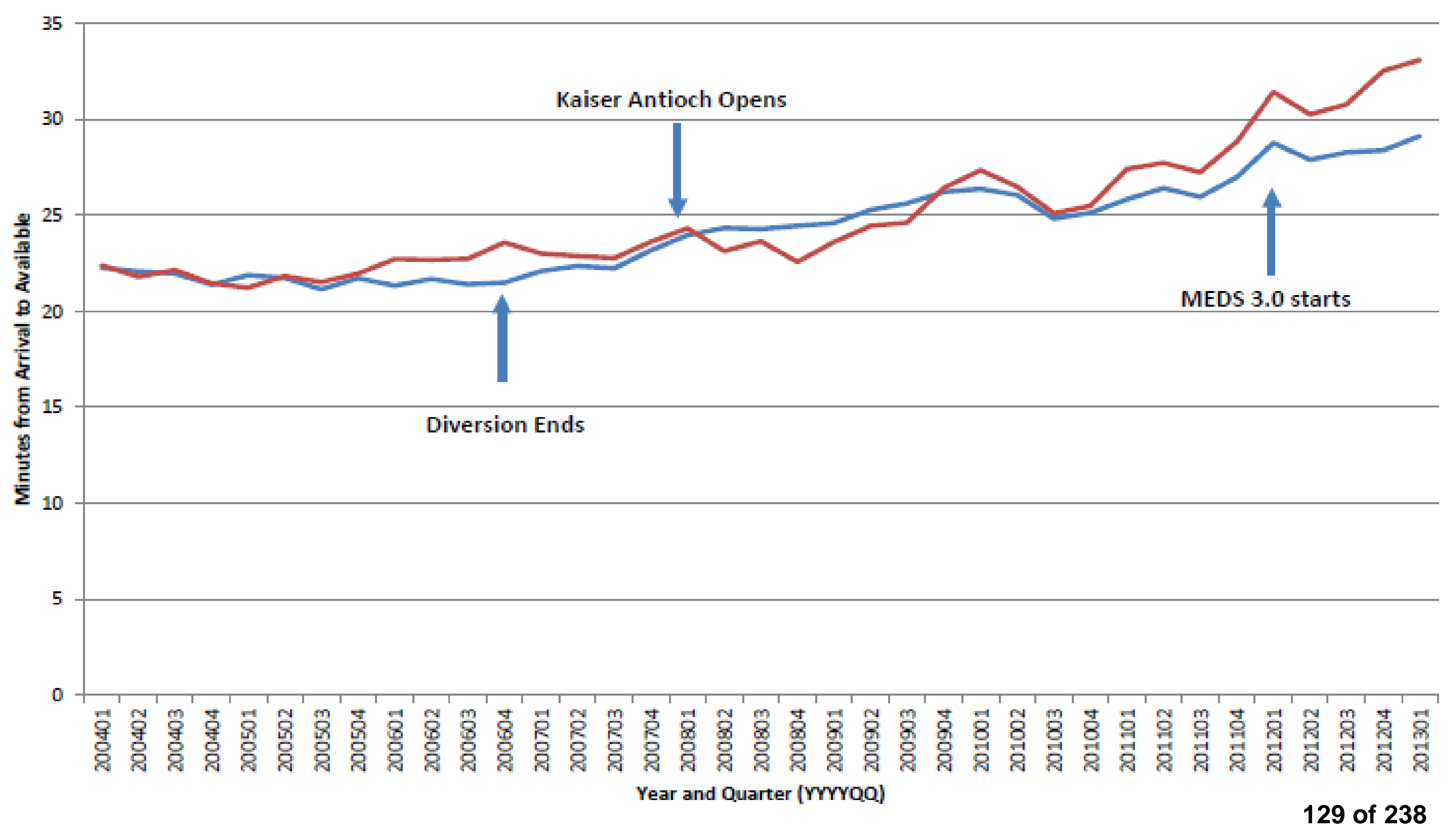
Never Events (>1 Hour Drop Time) By Patient Age	2013 (8/1/2013 - 12/31/2013)	2014 (1/1/2014 - 12/31/2014)	2015 (1/1/2015- 1/31/2015)	*Grand Total*
0-9	1	9	0	***10***
10-19	5	21	2	***28***
20-29	7	41	4	***52***
30-39	5	37	6	***48***
40-49	8	58	3	***69***
50-59	10	65	5	***80***
60-69	10	70	3	***83***
70-79	8	41	5	***54***
80-89	4	42	6	***52***
90-100	4	16	4	***24***
> 100	0	1	0	***1***

Never Event Patient Characteristics

Never Events (>1 Hour Drop Time) By Patient Gender	2013 (8/1/2013 - 12/31/2013)	2014 (1/1/2014 - 12/31/2014)	2015 (1/1/2015-1/31/2015)	*Grand Total*
Female	32	235	26	***293***
Male	30	166	12	***208***

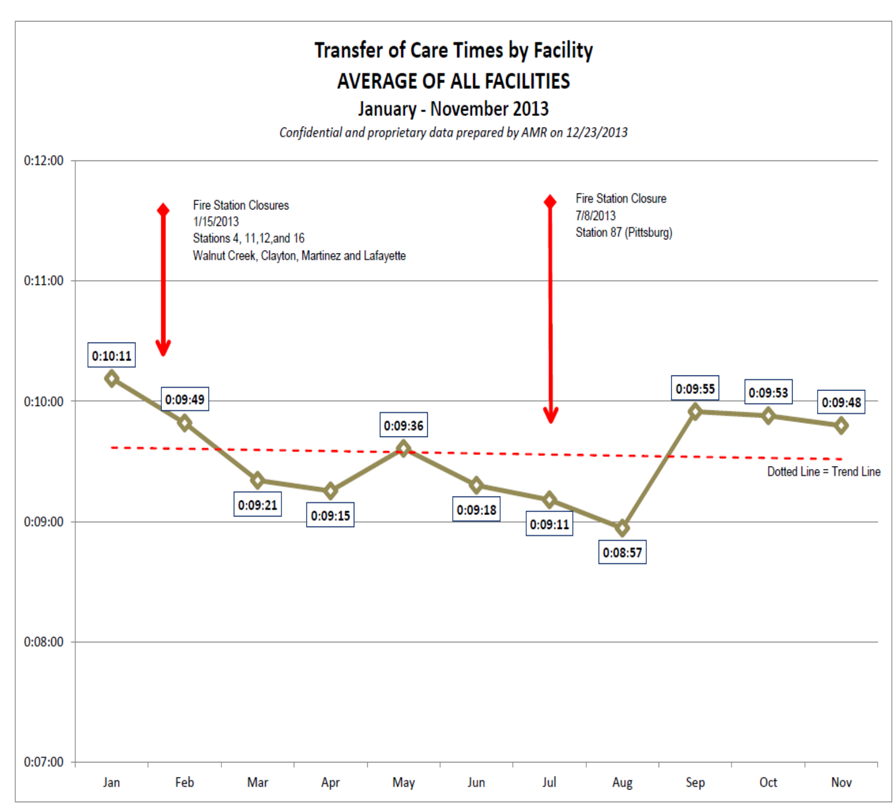
Never Events (>1 Hour Drop Time) By Patient Ethnicity	2013 (8/1/2013 - 12/31/2013)	2014 (1/1/2014 - 12/31/2014)	2015 (1/1/2015-1/31/2015)	*Grand Total*
Asian	2	17	0	***19***
Black/African American	19	106	9	***134***
Caucasian	29	200	20	***249***
Hispanic or Latino	11	49	7	***67***
Other Race	1	29	2	***32***

EMS/ED Volume, Workflow and System Impacts



EMS System Response
Fire Station Closures (January 2013)

- On January 3, 2013, CEO's and Emergency Departments (EDs) were requested to assist the EMS System to return ambulances to service ASAP by supporting prompt patient transfer of care for
- Conduct 911 transported patient handoff as soon as possible upon emergency ambulance arrival;
- Be prepared to take appropriate measures to effectively manage Emergency Department saturation
- Expedite patient handoff during peak periods when multiple 911 ambulances arrive.



Monitoring Consequences of EMS System Change

Post-DMC Closure to 9-1-1 Ambulance Traffic
August 7, 2014 (7:00 AM) to February 2, 2015

Hospital Patient Handoff Transfer of Care - Time from Arrival at Hospital to Documented Transfer of Care	Average Patient Handoff time (min)	Total Number of transports	90th Percentile (min) Handoff time exceeds this time in 10% of cases
Alta Bates	0:22:36	1,245	0:47:56
CCRMC	0:11:15	2,686	0:20:25
CCRMC - PES	0:14:56	3,542	0:29:00
Childrens Oakland	0:08:41	166	0:16:40
John Muir Concord	0:08:08	4,418	0:13:33
John Muir Walnut Creek	0:08:32	4,021	0:14:37
Kaiser Antioch	0:10:00	2,791	0:18:13
Kaiser Richmond	0:08:50	3,906	0:15:39
Kaiser Vallejo	0:11:22	402	0:20:00
Kaiser Walnut Creek	0:10:17	3,040	0:18:00
Other	0:13:19	533	0:25:48
Sutter Delta	0:17:34	4,377	0:37:05

EMS System Situation Status

Patient Handoff Times by Facility (90th Percentile)

Kaiser - Richmond

February 2014 - January 2015

6,837 Total Transports (570 per Month)

Source: AMR MEDS (ePCR Database)

Month & AMR Transport Volume	90th Percentile Handoff Time
Feb '14 441	0:15:01
Mar '14 445	0:14:00
Apr '14 453	0:14:00
May '14 564	0:14:16
Jun '14 485	0:13:38
Jul '14 496	0:13:33
Aug '14 695	0:15:10
Sep '14 771	0:16:37
Oct '14 651	0:15:51
Nov '14 604	0:14:45
Dec '14 648	0:15:19
Jan '15 584	0:15:32

Y-axis: 1:00:00, 0:55:00, 0:50:00, 0:45:00, 0:40:00, 0:35:00, 0:30:00, 0:25:00, 0:20:00, 0:15:00, 0:10:00, 0:05:00, 0:00:00

KP-Richmond began to implement CCEMS West County Directed Destination Protocol on 8/18/2014.

Month & AMR Transport Volume

What We Have Learned

- Hospitals with inpatient workflow practices that support emergency department throughput consistently demonstrate the shortest transfer of care times and experience significantly fewer “never events”
- Data is required to resolve bottlenecks to enhance patient and public safety
- Timely feedback and communication matters

Next Steps: Real Time Status Management

FIRST WATCH

Contra Costa County Hospital Status Dashboard
2/9/2015 7:19:56 PM

East	Enroute	Arrived	Elapsed - Avg	Elapsed - Max
Kaiser Antioch	0	0		
Sutter Delta	1	0		

Central	Enroute	Arrived	Elapsed - Avg	Elapsed - Max
Contra Costa Regional	0	2	16:36	22:44
John Muir - Concord	0	1	26:00	26:00
John Muir - Walnut Creek	0	0		
Kaiser Walnut Creek	0	0		
San Ramon Regional	0	0		

West	Enroute	Arrived	Elapsed - Avg	Elapsed - Max
Doctors San Pablo	0	0		
Kaiser Richmond	1	0		

Out of County	Enroute	Arrived	Elapsed - Avg	Elapsed - Max
Alameda County Medical Center	0	0		
Alta Bates	1	0		
Childrens Oakland	0	0		
Eden	0	0		
Helicopter Landing Zone	0	0		
Kaiser Oakland	0	0		
Kaiser Vallejo	2	0		
Marin General	0	0		
Summit	0	0		
Sutter Solano	0	0		
Valley Care	0	0		

Next Steps

AHRQ Health Care Innovations Exchange

Presentation for the California Hospital Association EMS/Trauma Committee

December 7, 2014

Shannon Fair, RN, MPH
Westat

The AHRQ Health Care Innovations Exchange provides a resource that supports decision making on the potential adoption and implementation of health care innovations and tools.

Primary goals:

- To accelerate the diffusion and uptake of novel methods of care delivery and policies to improve quality and reduce disparities in health care
- To facilitate the exchange of information, by providing:
  - usable information on health care innovations and quality improvement tools at www.innovations.ahrq.gov
  - learning and networking opportunities

Searchable database of service delivery and policy innovations and tools

- Includes successes and attempts
- Wide variety of sources including unpublished materials
- Vetted for effectiveness and applicability to patient care delivery
- Categorized for ease of use: extensive browse and search functions
- Innovators' stories and lessons learned
- Expert commentaries and perspectives

- Ranks among the higher scoring Federal Web sites measured by the American Customer Satisfaction Index (ACSI) Survey
- Attracts more than 50,000 users monthly
- Reaches more than 43,000 subscribers
- Expert Panel – 13 nationally known experts in health care delivery and innovation strategy provide strategic guidance on key issues
- Editorial Board – 6 nationally known editors and authors provide guidance on selection of content and strategies to enhance adoption and implementation of innovation

www.innovations.ahrq.gov

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Search for Innovation Profiles and QualityTools

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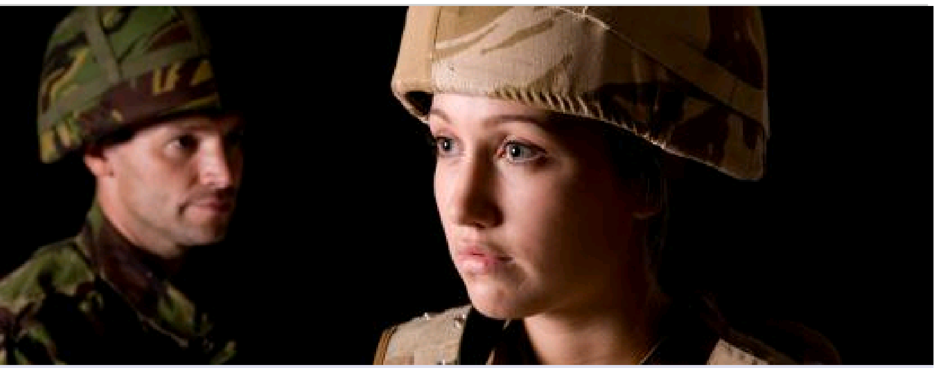


Enhancing Behavioral Health Services for Veterans

Innovative programs are increasing access to behavioral health services for veterans to improve outcomes.

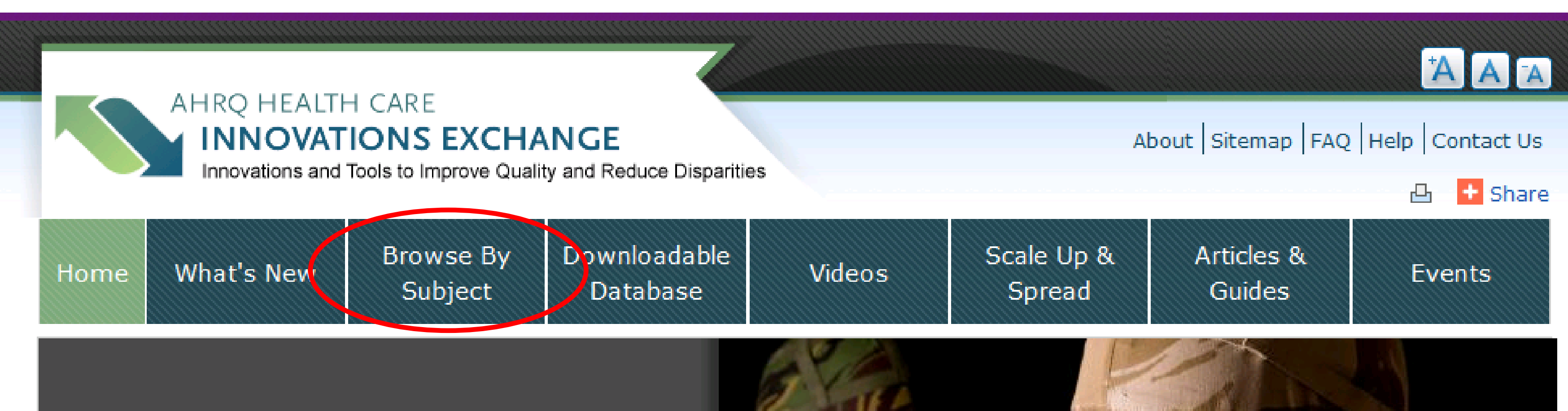
Currently 880+ Innovation Profiles

- Focus on service delivery and policy innovations
- Intent to improve health care quality and reduce disparities

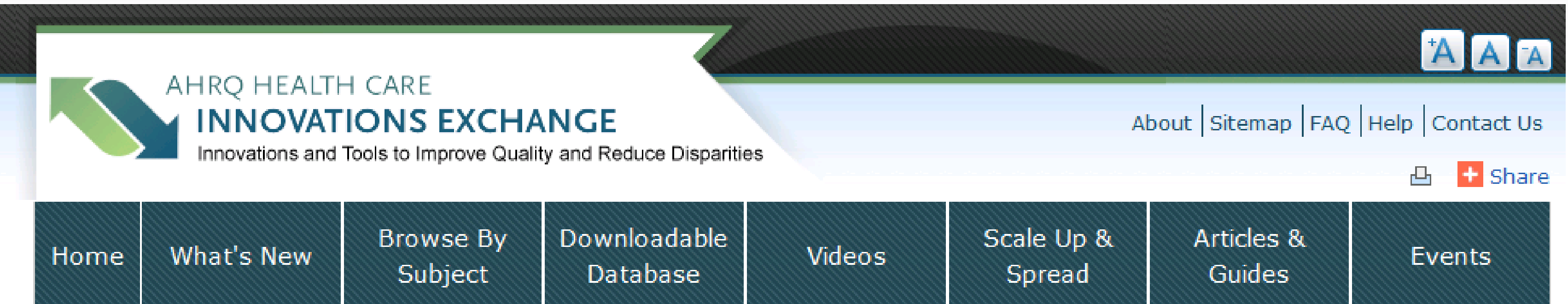
Currently 1,550 QualityTools

- Practical tools for assessing, measuring, promoting and improving health care quality
- Checklists, manuals, reports, and others

Ways to Find Relevant Content



Search Results



Search Results for emergency medical services

Innovations

Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs
An emergency medical services system uses a data-driven program to identify frequent 911 callers and facilitate access to community-based medical, social service, and other interventions to address their underlying needs, leading to significant reductions in emergency transports and associated costs.

Comprehensive Emergency Department and Inpatient Changes Improve Emergency Department Patient Satisfaction, Reduce Bottlenecks That Delay Admissions
To improve emergency department patient satisfaction and throughput, St. Francis Medical Center in Los Angeles implemented a comprehensive bundle of interrelated strategies.

Medical Emergency Team Reduces Cardiopulmonary Arrests, Unexpected Mortality
The creation of a medical emergency team program at the University of Pittsburgh Medical Center Presbyterian Hospital has significantly reduced the number of cardiopulmonary arrests and

Other Related Results

Issues

Enhancing Primary Care Access After Emergency Department Visits

Strategies To Address Frequent Emergency Department Use

Innovations in Emergency Medical Services

Identifying At-Risk Patients in the ED

The Patient-Centered Medical Home

Browse by Subject Options

Browse by Subject

Find Innovations and QualityTools by subject.

Disease Or Clinical Category

- Allergy and immunologic care (84)
- Cardiovascular care (252)
- Dental health care (35)
- Diet and nutrition (213)
- Endocrinologic/metabolic care (210)
- Gastroenterologic care (33)
- Gynecologic/obstetric care (150)
- Hematologic/oncologic care (243)
- HIV/aids care (96)
- Infectious disease care (248)
- Mental health care (268)
- Musculoskeletal care (191)
- Nephrologic care (28)
- Neurologic care (108)
- Ophthalmologic care (20)
- Otolaryngologic care (16)
- Pediatric care (166)
- Respiratory/pulmonary care (158)
- Skin and soft-tissue care (42)
- Substance abuse (180)
- Surgical care (41)
- Urologic care (6)

Find diseases by A–Z: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

IOM **IOM Domains Of Quality**

- Effectiveness (1,642)
- Efficiency (376)
- Equity (495)
- Not within an IOM domain (18)
- Patient-centeredness (1,351)
- Safety (600)
- Timeliness (223)

Organizational Processes Affected By The Innovation

- Active care processes: diagnosis and treatment (1,836)
- After care processes (447)
- Care management processes (911)
- Patient-focused processes/psychosocial care (1,597)
- Population health processes (731)
- Pre-care processes (215)
- Preventive care processes (1,010)
- Prevention and wellness (660)
- Quality improvement strategies (617)

Patient Population

Setting Of Care

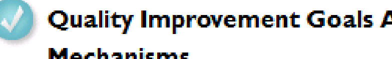
- Ambulatory setting (727)
- Ancillary service setting (30)
- Battlefield/military field hospital (4)
- Emergency setting (113)
- Health plans and managed care organizations (191)

Browse by Subject Options

- Medical record keeping (146)
- Organizational culture change (115)
- Pay for performance/incentives (60)
- Personal health records (31)
- Physical environment modification (92)
- Policies and procedures (415)
- Public communication (78)
- Quality measurement, benchmarking, data feedback (151)
- Referrals (219)
- Staff scheduling (30)
- Staffing (555)
- Team building (263)
- Technology—HIT (259)
- Technology—other (104)
- Training, knowledge management (529)
- Workflow redesign (166)

Patient Care Process

- Race and ethnicity (237)
- Vulnerable populations (1,415)



Quality Improvement Goals And Mechanisms

- Avoidable hospitalizations (142)
- Confidentiality/hipaa compliance (30)
- Cultural competence (199)
- Length of stay reduction/management (40)
- Medical home (61)
- Patient satisfaction (97)
- Rapid response teams (18)

QualityTool Topic

- Benchmarking/comparative data (104)
- Disease/condition-related (680)
- Guideline-related (123)
- Other (75)
- Patient/medication safety (314)

- Hospital inpatient —services/departments (109)
- Mobile (e.g., health vans) (14)
- Residential facilities (104)
- Safety net provider (65)
- Telehealth (179)

Stage Of Care

- Acute care (458)
- acute on chronic care (i.e., an acute condition resulting from underlying chronic disease) (17)
- Chronic care (603)
- Emergency care (137)
- End-of-life care (62)
- Intensive care (55)
- Long-term care (110)
- Preventive care (936)
- Primary care (587)
- Rehabilitation care (88)
- Urgent care (26)

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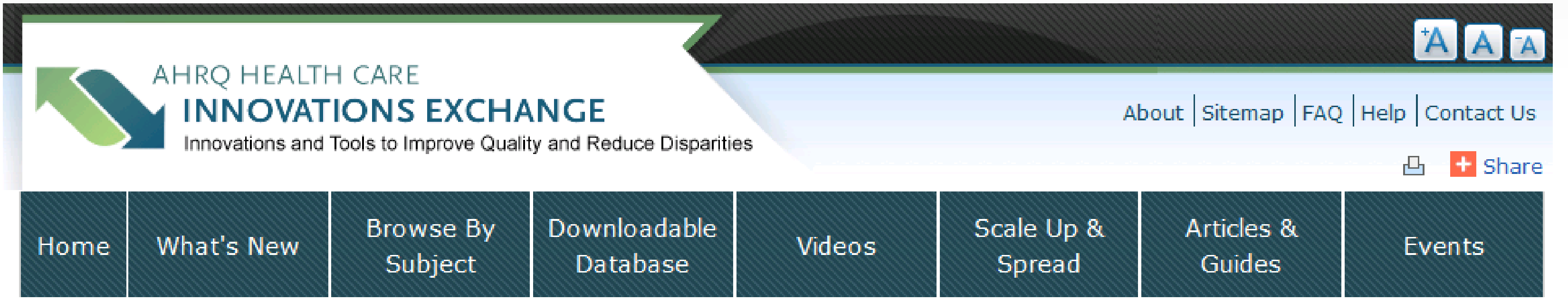
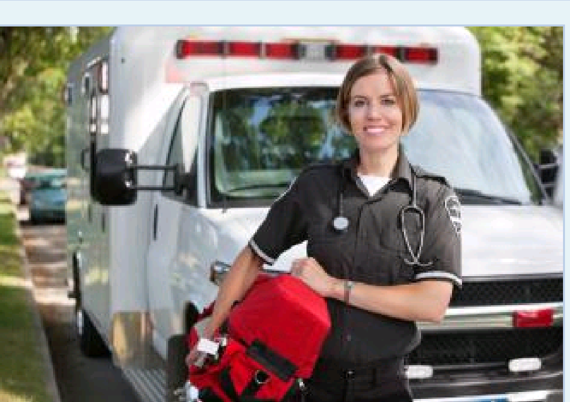
BACK TO TOP

Recent Publication Issue - Emergency Medical Services



Innovations in Emergency Medical Services | *Wednesday, June 4, 2014*

Inappropriate calls to emergency medical services (EMS) providers and unnecessary use of the emergency department (ED) occur frequently. Handling nonemergency calls raises the costs of providing EMS and ED services, diverts valuable resources away from true emergencies, and can result in delayed care, ED crowding, and poor patient outcomes.



The **featured Innovations** describe two programs that implemented innovative strategies to reduce the use of EMS by frequent 911 callers, leading to major cost savings and increased capacity in area EDs. The third featured profile describes a State policy that banned ambulance diversions to other nearby EDs, resulting in reduced ED length of stay and ambulance turnaround time.

Also in This Issue:

Innovations ▸

- Multifaceted Program Helps Pediatricians Screen for Maternal Depression and Assess Infant Crying and Toilet Training, Enhancing Their Ability To Prevent, Identify, and Address Cases of Potential Child Abuse
- Regular Meetings of Patients and Staff Reduce Violent Episodes by 85 Percent on Inpatient Psychiatric Unit
- Community-Driven Clinic for

Examples of Innovations - Emergency Medical Services

- Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs:

  https://innovations.ahrq.gov/profiles/data-driven-system-helps-emergency-medical-services-identify-frequent-callers-and-connect

- Statewide Ban on Ambulance Diversions Reduces Ambulance Turnaround Time and Emergency Department Length of Stay for Patients Admitted to the Hospital:

  https://innovations.ahrq.gov/profiles/statewide-ban-ambulance-diversions-reduces-ambulance-turnaround-time-and-emergency

- Trained Paramedics Provide Ongoing Support to Frequent 911 Callers, Reducing Use of Ambulance and Emergency Department Services:

  https://innovations.ahrq.gov/profiles/trained-paramedics-provide-ongoing-support-frequent-911-callers-reducing-use-ambulance-and

Examples of QualityTools - Emergency Medical Services

- Community Paramedic Evaluation Tool: https://innovations.ahrq.gov/qualitytools/community-paramedic-evaluation-tool
- Mission: Lifeline Tools and Resources: https://innovations.ahrq.gov/qualitytools/mission-lifeline-tools-and-resources
- Prehospital Medical Information System: https://innovations.ahrq.gov/qualitytools/prehospital-medical-information-system

Other Relevant Recent Publication Issues

- Identifying At-Risk Patients in the ED: https://innovations.ahrq.gov/issues/2013/11/20/identifying-risk-patients-ed
- Strategies To Address Frequent Emergency Department Use: https://innovations.ahrq.gov/issues/2013/10/23/strategies-address-frequent-emergency-department-use
- Alternative Care Settings To Reduce Hospital Use: https://innovations.ahrq.gov/issues/2013/03/13/alternative-care-settings-reduce-hospital-use
- Enhancing Primary Care Access After Emergency Department Visits: https://innovations.ahrq.gov/issues/2012/08/29/enhancing-primary-care-access-after-emergency-department-visits

How to Engage

- Search / Browse the site for strategies to address specific quality improvement challenges
- Provide feedback through the Comments feature
- Subscribe to email updates
- Follow us on Twitter: #AHRQIX
- Visit the Innovations Exchange LinkedIn page
  - Forum for discussion and collaboration with like-minded peers
  - Free and open to anyone who has a LinkedIn account
  - https://www.linkedin.com/groups/AHRQ-Health-Care-Innovations-Exchange-7436684?home=&gid=7436684

Questions?

CA AB 430 Trauma Care Systems R. Hernandez

Requires a local Emergency Medical Services agency implementing a trauma care system, to commission an independent nonprofit organization or governmental entity qualified to assess trauma systems to conduct a comprehensive regional assessment of equitability and access to its trauma system. Requires the assessment to be performed in conjunction with other local EMS agencies in that agency's region and the regional trauma coordinating committee.

Introduced 2/19/15
To ASSEMBLY Committee on HEALTH 3/2/15

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CA AB 503 Emergency Medical Services Rodriguez

Authorizes a health facility to release patient-identifiable medical information to a prehospital emergency medical services provider to the extent specific data elements are requested for quality assessment and improvement purposes.

Introduced 2/23/15
To ASSEMBLY Committee on HEALTH 3/5/15

==

CA AB 510 Emergency Services: 911 Emergency Communication System Rodriguez

Amends an existing law which requires the Office of Emergency Services to develop a plan and timeline of target dates for testing, implementing and operating a Next Generation 911 emergency communication system, including text to 911 service and to determine a certain surcharge rate.

Introduced 2/23/15
To ASSEMBLY Committee on GOVERNMENTAL ORGANIZATION 3/5/15

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22. CA AB 579 Health Facilities: Physical Plant Location Obernolte

Creates an exception to permit a general acute care hospital to operate an emergency department located more than 15 miles from its main physical plant, if all applicable requirements of licensure are satisfied.

Introduced 2/24/15
To ASSEMBLY Committee on HEALTH 3/9/15

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CA AB 643 Emergency Services: Silver Alerts Nazarian

Relates to a report of a missing person who is 65 years of age or older, developmentally disabled, or cognitively impaired. Authorizes the Silver Alert to be made by changeable message sign.

Introduced 2/24/15
To ASSEMBLY Committees on TRANSPORTATION and AGING AND LONG-TERM CARE 3/9/15

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CA AB 896 Counties: Search or Rescue: Costs Wagner

Relates to liability for specified emergency response expenses. Provides that whenever a county or city and county receives a reimbursement claim from another county or city and county for a search or rescue, or conducts its own search or rescue, of one of its residents who is 16 years of age or older, the county or city and county may in turn seek reimbursement for costs incurred from that resident.

Introduced 2/26/15

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CA AB 1129 Emergency Medical Services: Data and Information System Burke

Requires an emergency medical care provider to, when collecting and sharing data with a local EMS agency, use a system that is compliant with the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and ensure that the system can be integrated with the local EMS agency's system.

Introduced 2/27/15

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CA AB 1223 Emergency Medical Services: Noncritical Cases O'Donnell

Relates to the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act. Allows for the transportation of a noncritical case that cannot be immediately admitted to a hospital emergency room to another appropriate medical treatment facility, including, but not limited to, a clinic or doctors' office.

Introduced 2/27/15

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CA SB 145 Health Facilities: Patient Transporting Pan

Prohibits a general acute care hospital, acute psychiatric hospital, or special hospital from causing a patient with a blood alcohol content of 0.8 percent or greater to be transported to another location except when the patient is either medically stabilized or appropriately transferred to another health facility pursuant to another provision of law. Makes violation subject to civil penalties.

Introduced 1/2/7/15
To SENATE Committees on HEALTH AND JUDICIARY 2/5/15

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CA SB 534 Medi-Cal: Ground Emergency Medical Transportation Pan

Makes technical, nonsubstantive changes to provisions of Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services.

Introduced 2/26/15

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CA SB 658 Automated External Defibrillators Hill

Removes the conditions required for the exemption from civil liability of a person or entity that acquires an automatic external defibrillator (AED) for emergency use and any person or entity responsible for the site where the AED is located. Requires a person or entity that acquires an AED to comply with specified regulations for the placement of the device and ensure that the AED is maintained and annually tested.

Introduced 2/27/15

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CA SB 700 Emergency Medical Services Berryhill

Makes technical nonsubstantive changes to existing law that establishes minimum standards and promulgates regulations for the training and scope of practice for emergency medical technician-paramedic (EMP-P).

Introduced 2/27/15

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california legislature—2015–16 regular session

ASSEMBLY BILL No. 503

Introduced by Assembly Member Rodriguez

February 23, 2015

An act to add Section 1797.122 to the Health and Safety Code, relating to emergency medical services.

legislative counsel's digest

AB 503, as introduced, Rodriguez. Emergency medical services.

Existing law requires the Emergency Medical Services Authority to develop planning and implementation guidelines for emergency medical services (EMS) systems that address several components, including, but not limited to, manpower and training, communications, transportation, and assessment of hospitals and critical care centers.

This bill would authorize a health facility, as defined, to release patient-identifiable medical inform a prehospital emergency medical services provider to the extent specific data elements are requested for quality assessment and improvement purposes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1797.122 is added to the Health and
2 Safety Code, to read:
3 1797.122. (a) Notwithstanding any other law, a health facility
4 as defined in subdivision (a) or (b) of Section 1250 may, but is not
5 required to, release patient-identifiable medical information under
6 the following circumstances:

1 (1) To a prehospital emergency medical services provider
2 information regarding a patient who was transported to the hospital
3 by that prehospital emergency medical services provider, to the
4 extent that specific data elements are requested for quality
5 assessment and improvement purposes.
6 (2) To the Emergency Medical Services Authority or the local
7 emergency medical services agency, to the extent that specific data
8 elements are requested for quality assessment and improvement
9 purposes.
10 (b) Each prehospital emergency medical services provider and
11 local emergency medical services agency, and the Emergency
12 Medical Services Authority shall request only those data elements
13 that are minimally necessary in compliance with Section 164.502
14 (b) and Section 164.514 (d) of Title 45 of the Code of Federal
15 Regulations.

O

Freestanding Emergency Departments
Fact Sheet

Background:

Since 1990, the number of hospital-based emergency departments (EDs) has declined while the usage by patients has increased. California EDs are struggling to keep up with the demand of a growing population thus restricting access to healthcare in some communities.

Solution:

One increasingly popular option that has been utilized by other states to improve access to services is the creation of a freestanding emergency department (FSED). For example, a FSED may be open to the public 24 hours a day so patients can be treated for urgent as well as emergent, medical conditions. FSEDs are staffed with the same medical personnel and diagnostic equipment found in any other hospital-based emergency room. One of the main differences between a FSED and a traditional hospital-based emergency room is that FSEDs are not located on a hospital campus and thus not attached to a hospital. Currently, there is no licensing option in California that allows for a FSED.

A freestanding ED will:

- Comply with federal requirements, including EMTALA, Centers for Medicare & Medicaid Services hospital-based ED standards, transfer protocols for patients needing admission or more definitive care, state staffing ratios, peer and quality review and seismic standards.
- Provide authority for each Local Emergency Medical Services Authority to determine 911 transport protocols to ensure appropriate transfer of patients to FSED or hospital EDs.

Difference between a FSED and an Urgent Care facility:

- A FSED is open 24 hours a day/365 days a year as opposed to an urgent care facility that may be open only 8-12 hours a day.
- FSED are capable of treating urgent, as well as emergent, medical conditions such as heart attacks, dehydration, abdominal pains, sports injuries, cuts that require sutures and other injuries and illnesses.

Support
California Hospital Association

Opposition
Unknown at this time

1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

ASSEMBLY BILL No. 579

Introduced by Assembly Member Obernolte

February 24, 2015

An act to amend Section 1250.8 of the Health and Safety Code, relating to health facilities.

legislative counsel's digest

AB 579, as introduced, Obernolte. Health facilities: physical plant location.

Existing law requires the State Department of Public Health to issue a single consolidated license to a general acute care hospital that includes more than one physical plant maintained and operated on separate premises if all applicable requirements of licensure, as specified, are satisfied. Under existing law, the physical plants maintained and operated under a general acute care hospital's single consolidated license must be located no more than 15 miles apart, unless a specified exception applies.

This bill would create an exception to permit a general acute care hospital to operate an emergency department located more than 15 miles from its main physical plant, if all applicable requirements of licensure are satisfied.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1250.8 of the Health and Safety Code is
2 amended to read:

1 1250.8. (a) Notwithstanding subdivision (a) of Section 127170,
2 the department, upon application of a general acute care hospital
3 that meets all the criteria of subdivision (b), and other applicable
4 requirements of licensure, shall issue a single consolidated license
5 to a general acute care hospital that includes more than one physical
6 plant maintained and operated on separate premises or that has
7 multiple licenses for a single health facility on the same premises.
8 A single consolidated license shall not be issued where the separate
9 freestanding physical plant is a skilled nursing facility or an
10 intermediate care facility, whether or not the location of the skilled
11 nursing facility or intermediate care facility is contiguous to the
12 general acute care hospital unless the hospital is exempt from the
13 requirements of subdivision (b) of Section 1254, or the facility is
14 part of the physical structure licensed to provide acute care.
15 (b) The issuance of a single consolidated license shall be based
16 on the following criteria:
17 (1) There is a single governing body for all the facilities
18 maintained and operated by the licensee.
19 (2) There is a single administration for all the facilities
20 maintained and operated by the licensee.
21 (3) There is a single medical staff for all the facilities maintained
22 and operated by the licensee, with a single set of bylaws, rules,
23 and regulations, ~~which~~ *that* prescribe a single committee structure.
24 (4) Except as provided otherwise in this paragraph, the physical
25 plants maintained and operated by the licensee which are to be
26 covered by the single consolidated license are located not more
27 than 15 miles apart. If an applicant provides evidence satisfactory
28 to the department that it can comply with all requirements of
29 licensure and provide quality care and adequate administrative and
30 professional supervision, the director may issue a single
31 consolidated license to a general acute care hospital that operates
32 two or more physical plants located more than 15 miles apart under
33 any of the following circumstances:
34 (A) One or more of the physical plants is located in a rural area,
35 as defined by regulations of the director.
36 (B) One or more of the physical plants provides only outpatient
37 services, as defined by the department.
38 *(C) One or more of the physical plants is an emergency*
39 *department, as defined in subdivision (b) of Section 128700.*
40 ~~(C)~~

1 *(D)* If Section 14105.986 of the Welfare and Institutions Code
2 is implemented and the applicant meets all of the following criteria:
3 (i) The applicant is a nonprofit corporation.
4 (ii) The applicant is a children's hospital listed in Section 10727
5 of the Welfare and Institutions Code.
6 (iii) The applicant is affiliated with a major university medical
7 school and located adjacent thereto.
8 (iv) The applicant operates a regional tertiary care facility.
9 (v) One of the physical plants is located in a county that has a
10 consolidated and county government structure.
11 (vi) One of the physical plants is located in a county having a
12 population between 1,000,000 and 2,000,000.
13 (vii) The applicant is located in a city with a population between
14 50,000 and 100,000.
15 (c) In issuing the single consolidated license, the state
16 department shall specify the location of each supplemental service
17 and the location of the number and category of beds provided by
18 the licensee. The single consolidated license shall be renewed
19 annually.
20 (d) To the extent required by Chapter 1 (commencing with
21 ~~Section127125)~~ *Section 127125)* of Part 2 of Division 107, a
22 general acute care hospital that has been issued a single
23 consolidated license:
24 (1) Shall not transfer from one facility to another a special
25 service described in Section 1255 without first obtaining a
26 certificate of need.
27 (2) Shall not transfer, in whole or in part, from one facility to
28 another, a supplemental service, as defined in regulations of the
29 director pursuant to this chapter, without first obtaining a certificate
30 of need, unless the licensee, 30 days prior to the relocation, notifies
31 the Office of Statewide Health Planning and Development, the
32 applicable health systems agency, and the state department of the
33 licensee's intent to relocate the supplemental service, and includes
34 with this notice a cost estimate, certified by a person qualified by
35 experience or training to render the estimates, which estimates that
36 the cost of the transfer will not exceed the capital expenditure
37 threshold established by the Office of Statewide Health Planning
38 and Development pursuant to Section 127170.
39 (3) Shall not transfer beds from one facility to another facility,
40 without first obtaining a certificate of need unless, 30 days prior

1 to the relocation, the licensee notifies the Office of Statewide
2 Health Planning and Development, the applicable health systems
3 agency, and the state department of the licensee's intent to relocate
4 health facility beds, and includes with this notice both of the
5 following:
6 (A) A cost estimate, certified by a person qualified by experience
7 or training to render the estimates, which estimates that the cost
8 of the relocation will not exceed the capital expenditure threshold
9 established by the Office of Statewide Health Planning and
10 Development pursuant to Section 127170.
11 (B) The identification of the number, classification, and location
12 of the health facility beds in the transferor facility and the proposed
13 number, classification, and location of the health facility beds in
14 the transferee facility.
15 Except as otherwise permitted in Chapter 1 (commencing with
16 Section 127125) of Part 2 of Division 107, or as authorized in an
17 approved certificate of need pursuant to that chapter, health facility
18 beds transferred pursuant to this section shall be used in the
19 transferee facility in the same bed classification as defined in
20 Section 1250.1, as the beds were classified in the transferor facility.
21 Health facility beds transferred pursuant to this section shall not
22 be transferred back to the transferor facility for two years from the
23 date of the transfer, regardless of cost, without first obtaining a
24 certificate of need pursuant to Chapter 1 (commencing with Section
25 127125) of Part 2 of Division 107.
26 (e) Transfers pursuant to subdivision (d) shall satisfy all
27 applicable requirements of licensure and shall be subject to the
28 written approval, if required, of the state department. The state
29 department may adopt regulations that are necessary to implement
30 this section. These regulations may include a requirement that each
31 facility of a health facility subject to a single consolidated license
32 have an onsite full-time or part-time administrator.
33 (f) As used in this section, "facility" means a physical plant
34 operated or maintained by a health facility subject to a single,
35 consolidated license issued pursuant to this section.
36 (g) For purposes of selective provider contracts negotiated under
37 the Medi-Cal program, the treatment of a health facility with a
38 single consolidated license issued pursuant to this section shall be
39 subject to negotiation between the health facility and the California
40 Medical Assistance Commission. A general acute care hospital

1 that is issued a single consolidated license pursuant to this section
2 may, at its option, be enrolled in the Medi-Cal program as a single
3 business address or as separate business addresses for one or more
4 of the facilities subject to the single consolidated license.
5 Irrespective of whether the general acute care hospital is enrolled
6 at one or more business addresses, the department may require the
7 hospital to file separate cost reports for each facility pursuant to
8 Section 14170 of the Welfare and Institutions Code.
9 (h) For purposes of the Annual Report of Hospitals required by
10 regulations adopted by the state department pursuant to this part,
11 the state department and the Office of Statewide Health Planning
12 and Development may require reporting of bed and service
13 utilization data separately by each facility of a general acute care
14 hospital issued a single consolidated license pursuant to this
15 section.
16 (i) The amendments made to this section during the 1985–86
17 Regular Session of the Legislature pertaining to the issuance of a
18 single consolidated license to a general acute care hospital in the
19 case where the separate physical plant is a skilled nursing facility
20 or intermediate care facility shall not apply to the following
21 facilities:
22 (1) A facility that obtained a certificate of need after August 1,
23 1984, and prior to February 14, 1985, as described in this
24 subdivision. The certificate of need shall be for the construction
25 of a skilled nursing facility or intermediate care facility that is the
26 same facility for which the hospital applies for a single consolidated
27 license, pursuant to subdivision (a).
28 (2) A facility for which a single consolidated license has been
29 issued pursuant to subdivision (a), as described in this subdivision,
30 prior to the effective date of the amendments made to this section
31 during the 1985–86 Regular Session of the Legislature.
32 A facility that has been issued a single consolidated license
33 pursuant to subdivision (a), as described in this subdivision, shall
34 be granted renewal licenses based upon the same criteria used for
35 the initial consolidated license.
36 (j) If the state department issues a single consolidated license
37 pursuant to this section, the state department may take any action
38 authorized by this chapter, including, but not limited to, any action
39 specified in Article 5 (commencing with Section 1294), with

1 respect to a facility, or a service provided in a facility, that is
2 included in the consolidated license.
3 (k) The eligibility for participation in the Medi-Cal program
4 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
5 9 of the Welfare and Institutions Code) of a facility that is included
6 in a consolidated license issued pursuant to this section, provides
7 outpatient services, and is located more than 15 miles from the
8 health facility issued the consolidated license shall be subject to a
9 determination of eligibility by the state department. This
10 subdivision shall not apply to a facility that is located in a rural
11 area and is included in a consolidated license issued pursuant to
12 subparagraphs (A), (B), and (C) of paragraph (4) of subdivision
13 (b). Regardless of whether a facility has received or not received
14 a determination of eligibility pursuant to this subdivision, this
15 subdivision shall not affect the ability of a licensed professional,
16 providing services covered by the Medi-Cal program to a person
17 eligible for Medi-Cal in a facility subject to a determination of
18 eligibility pursuant to this subdivision, to bill the Medi-Cal program
19 for those services provided in accordance with applicable
20 regulations.
21 (*l*) Notwithstanding any other provision of law, the director may
22 issue a single consolidated license for a general acute care hospital
23 to Children's Hospital Oakland and San Ramon Regional Medical
24 Center.
25 (m) Notwithstanding any other provision of law, the director
26 may issue a single consolidated license for a general acute care
27 hospital to Children's Hospital Oakland and the John Muir Medical
28 Center, Concord Campus.
29 (n) (1) To the extent permitted by federal law, payments made
30 to Children's Hospital Oakland pursuant to Section 14166.11 of
31 the Welfare and Institutions Code shall be adjusted as follows:
32 (A) The number of Medi-Cal payment days and net revenues
33 calculated for the John Muir Medical Center, Concord Campus
34 under the consolidated license shall not be used for eligibility
35 purposes for the private hospital disproportionate share hospital
36 replacement funds for Children's Hospital Oakland.
37 (B) The number of Medi-Cal payment days calculated for
38 hospital beds located at John Muir Medical Center, Concord
39 Campus that are included in the consolidated license beginning in
40 the 2007–08 fiscal year shall only be used for purposes of

1 calculating disproportionate share hospital payments authorized
2 under Section 14166.11 of the Welfare and Institutions Code at
3 Children's Hospital Oakland to the extent that the inclusion of
4 those days does not exceed the total Medi-Cal payment days used
5 to calculate Children's Hospital Oakland payments for the 2006–07
6 fiscal year disproportionate share replacement.
7 (2) This subdivision shall become inoperative in the event that
8 the two facilities covered under the consolidated license described
9 in subdivision (a) are located within a 15-mile radius of each other.

O

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY EDMUND G. BROWN JR., *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

DATE: March 13, 2015

TO: Emergency Medical Directors Association of California (EMDAC)
Emergency Medical Services Administrators Association of California (EMSAAC)
Local EMS Agency Administrators
Local EMS Agency Medical Directors
Emergency Nurses Association
California Hospital Association
California Department of Public Health
California Ambulance Association
California Fire Chiefs Association
California Hospital Association
California Health and Human Services Agency
California Highway Patrol
California Medical Association
California Rescue and Paramedic Association
California Nurses Association
California State Firefighters Association
Commission on Emergency Medical Services
California Professional Firefighters
Other Interested Parties

FROM: Howard Backer, MD, MPH, FACEP
Director, EMS Authority

SUBJECT: PUBLIC COMMENT FOR THE DRAFT REGULATIONS ON APPEAL PROCEEDINGS TO THE COMMISSION

The Emergency Medical Services (EMS) Authority has opened the public comment period for the draft regulations on the Appeal Proceedings to the Commission. The draft regulations may be viewed on the EMS Authority's website at www.emsa.ca.gov. Click on the Public Comment link under Popular Links.

Interested parties are invited to submit written comments on the draft regulations during this public comment period which will be from March 13, 2015 to April 27, 2015. All comments must be received by the EMS Authority by **5:00 p.m. on April 27, 2015.**

EMSA will conduct a public hearing on **April 27, 2015**. The hearing will begin at **2:00 pm and end at 4:00 pm**. The hearing will be held at EMSA Headquarters located at 10901 Gold Center Drive, Suite 400, Rancho Cordova, CA 95670. EMSA requests that persons making oral comments at the hearing also submit a written copy of their testimony at the hearing.

Comments should be submitted in such a manner that they clearly indicate which portions of the draft regulations they are referencing. Please submit comments on the Appeal Proceedings to the Commission Regulations comment form, including section, page and line numbers for each item being commented on as well as the name and organization of the commenter for each comment submitted. The comment form is attached to this email and may also be found at the Public Comment link.

Comment forms may be submitted to:

California EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670-6073
Attn: Teri Harness, Assitant Division Chief
EMS Systems Division
teri.harness@emsa.ca.gov

If you would like a copy of the draft regulations mailed, faxed or emailed to you, or if you have any questions, please contact Teri Harness at (916) 431-3708, or by email at teri.harness@emsa.ca.gov.

NOTICE OF PROPOSED RULEMAKING
[Notice published March 13, 2015]

TITLE 22. SOCIAL SECURITY
DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 13: EMS SYSTEM REGULATIONS
APPEAL PROCEEDINGS TO THE COMMISSION

The Emergency Medical Services Authority (EMSA) proposes to adopt the proposed regulations described below after considering all comments, objections, and recommendations regarding the proposed action.

PUBLIC HEARING

EMSA will conduct a public hearing on **April 27, 2015**. The hearing will begin at **2:00 pm and end at 4:00 pm**. The hearing will be held at EMSA Headquarters located at 10901 Gold Center Drive, Suite 400, Rancho Cordova, CA 95670. EMSA requests that persons making oral comments at the hearing also submit a written copy of their testimony at the hearing.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action, to EMSA. Comments may also be submitted by facsimile (FAX) at (915) 324-2875 or by e-mail to teri.harness@emsa.ca.gov. The written comment period closes at **4:00 p.m.** on **April 27, 2015**. EMSA will only consider comments received at EMSA Headquarters by that time. Submit comments to:

Teri Harness, Assistant Division Chief
EMS Systems Division
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

AUTHORITY AND REFERENCE

The Health and Safety Code (H&SC), Section 1797.107 authorizes EMSA to adopt the proposed regulations, which would implement, interpret, and make specific Section 1797.105(c) and (d) of the H&SC.

INFORMATIVE DIGEST/ POLICY STATEMENT OVERVIEW

Existing law requires EMSA to review emergency medical services (EMS) plans received from local EMS agencies (LEMSAs). EMSA is required to either approve or

disapprove the plan based on whether the plan meets specific requirements. LEMSAs are permitted to appeal an EMSA determination to the EMS Commission.

The regulations proposed in this rulemaking action would establish the appeal procedures to the EMS Commission. All appeal hearings to the Commission would be conducted through the Administrative Procedure Act. An administrative law judge (ALJ), within the Office of Administrative Hearings (OAH), would evaluate evidence submitted by EMSA and the LEMSA. The ALJ would provide a recommendation to the Commission to either sustain the determination of EMSA, or overrule the determination of EMSA. The Commission would then vote on the proposed decision at the next regularly scheduled Commission meeting. The Commission's vote on the proposed decision would be limited to either adopt or not adopt the ALJs proposed decision, or return the proposed decision to the OAH for re-hearing if the proposed decision is inconsistent with the regulations or statute.

Anticipated Benefits of the Proposed Regulation:
Adoption of the regulations will avoid serious harm to the public peace, health, safety and general welfare by adopting an appeal process for LEMSAs when an EMS plan is disapproved. In addition, the regulations will allow three (3) pending appeals to advance forward and ensure due process to the LEMSAs under state law.

Determination of Inconsistency/Incompatibility with Existing State Regulations:
EMSA has determined that this proposed regulation is not inconsistent or incompatible with existing regulations. After conducting a review for any regulations that would relate to or affect this area, EMSA has concluded that these regulations will not cause inconsistency or incompatibility with other existing regulations that concern EMS plan appeals.

DISCLOSURES REGARDING THE PROPOSED ACTION

EMSA has made the following initial determinations:

- Mandate on local agencies and school districts: None
- Cost or savings to any state agency: None
- Cost to any local agency or school district which must be reimbursed in accordance with Government Code Sections 17500 through 17630: None
- Other nondiscretionary cost or savings imposed on local agencies: None
- Cost or savings in federal funding to the state: None
- Cost impacts on a representative private person or business: EMSA is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

- Significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None

- Significant effect on housing costs: None

- The proposed regulations will not affect small business because the establishment of the appeal process only applies to the 33 LEMSAs within California. The regulations have no significance to small businesses.

Results of the Economic Impact Analysis

EMSA concludes that it is (1) unlikely that the regulations will eliminate any jobs for ambulance providers; (2) possible that the regulations will create an unknown number of jobs for ambulance providers; (3) likely that the proposal will create an unknown number of new private ambulance companies providing ambulance services; (4) unlikely that the proposal will eliminate any existing businesses; (5) unlikely that the proposed regulations will result in the expansion of businesses currently doing businesses within the State; and (6) benefit California residents by providing this means of resolution between EMSA and LEMSAs concerning emergency medical services plans which would ultimately lead to protection of the public peace, health, safety, and general welfare.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(13), EMSA must determine that no reasonable alternative considered, or otherwise identified and brought to the attention of the agency, would be more effective in carrying out the purpose for which the action is proposed, or would be as effective and less burdensome to affected private persons than the proposed action or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

EMSA invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

Teri Harness, Assistant Division Chief
EMS Systems Division
EMS Authority
10901 Gold Center Drive, Suite 400

Rancho Cordova, CA 95670
(916) 431-3708
teri.harness@emsa.ca.gov

The backup contact person for these inquiries is:

Kathy Bissell, Manager
EMS Systems Division
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670
(916) 431-3687
Kathy.bissell-benabides@emsa.ca.gov

Please direct requests for copies of the proposed text (the "express terms") of the regulations, the initial statement of reasons (ISORS), the modified text of the regulations, if any, or other information upon which the rulemaking is based, to Teri Harness at the above address.

AVAILABILITY OF STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, AND RULEMAKING FILE

EMSA will have the entire rulemaking file available for inspection and copy throughout the rulemaking process at its office at the above address. As of the date this notice is published in the Notice Register, the rulemaking file consists of this notice, the proposed text of the regulations, and the ISORS. Copies may be obtained by contacting Teri Harness at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After conducting the public hearing and considering all timely and relevant comments received, EMSA may adopt the proposed regulations substantially as described in this notice. If EMSA makes modifications which are sufficiently related to the originally proposed text, it will make the modified text (with the changes clearly indicated) available to the public for at least 15 days before EMSA adopts the regulation as revised. Please send requests for copies of any modified regulations to the attention of Teri Harness at the address indicated on the previous page. EMSA will accept written comments on any modified regulations for 15 days after the date on which they were made available.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, copies of the Final Statement of Reasons may be obtained by contacting Teri Harness at the address provided on the previous page.

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Action, the ISORS, and the text of the regulations in underline and strikeout may be accessed through EMSAs website at www.emsa.ca.gov.

INITIAL STATEMENT OF REASONS
CHAPTER 13 EMS SYSTEMS REGULATIONS
APPEAL PROCEEDINGS TO THE COMMISSION

Hearing Date: April 27, 2015

Subject Matter of Proposed Regulations: Appeal Process for EMS Agencies when EMS Plan is denied.

Section Affected: Add Section 100450.100 to Division 9 of the California Code of Regulations.

PROBLEM STATEMENT
There is currently no appeal process in place for local EMS agencies (LEMSAs) to appeal a determination by the Emergency Medical Services Authority (EMSA) on an EMS plan. Lack of regulations specifying the appeal process has resulted in pending appeals and the denial of due process under state law.

PURPOSE
The purpose of this regulation is to avoid serious harm to the public peace, health, safety, or general welfare by implementing an appeal process for LEMSAs when an EMS plan is disapproved by EMSA. In addition, the implementation of the regulations will provide the LEMSAs with due process under state law.

BENEFITS
The regulations will avoid serious harm to the public peace health, safety, or general welfare and will make specific the regulations at Health and Safety Code (HSC) § 1797.105(c) which permits LEMSAs to appeal a determination by EMSA to disapprove an EMS Plan. This will allow three pending appeals to advance forward and ensure due process to the LEMSAs.

PURPOSE AND NECESSITY OF ADOPTION OF REGULATIONS

Chapter 13. EMS Systems Regulations
Section 100450.100. Appeal Proceedings of the Commission

SPECIFIC PURPOSE
Section 100450.100 is adopted to avoid serious harm to the public peace, health, safety, or general welfare by implementing an appeal process for LEMSAs when an EMS plan is disapproved by EMSA. In addition, the implementation of the regulations will provide the LEMSAs with due process under state law.

NECESSITY
This adoption is necessary to make specific HSC § 1797.105(c) which permits LEMSAs to appeal a determination by EMSA to disapprove an EMS Plan.

ECONOMIC IMPACT ANALYSIS

The proposed regulations are designed to provide local EMS agencies due process to appeal the denial of an EMS Plan, in accordance with Health and Safety Code, Section 1797.105. LEMSAs may appeal the denial of their EMS plan based on a number of factors. Since the pending appeals focus primarily on the Response and Transportation component of the EMS Plan, the economic impact analysis is based on changes to exclusive operating areas.

Creation or Elimination of Jobs within the State of California

The impact to the creation or elimination of jobs within the State of California will be dependent on which way the Commission on EMS rules in an appeal. If the Commission on EMS sustains a denial and allows an area to be non-exclusive, it could cause an elimination of jobs if the current provider is unable to pay employees due to loss of revenue. On the contrary, it could create jobs by allowing more ambulance providers to conduct business in the area and create the need to hire more employees. In the event a denial is overruled, the area will remain the same with no creation or elimination of jobs.

Creation of New or Elimination of Existing Businesses within the State of California

The impact to the creation of new or elimination of existing businesses with the State of California will be dependent on which way the Commission on EMS rules in an appeal. If the Commission on EMS sustains a denial and allows an area to be non-exclusive, it could cause elimination of an ambulance company if the current provider can no longer sustain operating costs due to loss of revenue. On the contrary, it could allow the creation of new ambulance companies who would like to be included in call rotations within an EMS system. In the event a denial is overruled, the area will remain the same with no creation or elimination of existing businesses.

Expansion of Businesses or Elimination of Existing Businesses within the State of California

The impact to the expansion of businesses or elimination of existing businesses with the State of California will be dependent on which way the Commission on EMS rules in an appeal. If the Commission on EMS sustains a denial and allows an area to be non-exclusive, it could cause an elimination of an ambulance company if the current provider can no longer sustain operating cost due to loss of revenue. On the contrary, it could allow current provider companies from other counties to expand into new areas and be included in call rotations within an EMS system. In the event a denial is overruled, the area will remain the same with no expansion or elimination of existing businesses.

FOR FURTHER INFORMATION

Contact Teri Harness, Emergency Medical Services Authority, 10901 Gold Center Drive, Suite 400, Rancho Cordova, California 95670, (916) 431-3708, e-mail teri.harness@emsa.ca.gov.

California Code of Regulations

TITLE 22. SOCIAL SECURITY

DIVISION 9. PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

CHAPTER 13. EMS System Regulations

Adopt Section 100450.100 to read:

§ 100450.100 . Appeal Proceedings to the Commission

(a) Any proceeding by the Commission to hear an appeal of a local emergency medical services agency's (LEMSA) emergency medical services (EMS) plan, pursuant to Health and Safety Code §1797.105, shall be conducted in accordance with the provisions of the Administrative Procedure Act, Government Code Section 11500 et seq, and its associated regulations as contained in Title 1 of the California Code of Regulations.

(b) The Office of Administrative Hearings, using an administrative law judge, shall evaluate all information submitted by the Authority and the local EMS agency.

(c) The administrative law judge, in making a proposed decision to the Commission, shall only make a recommendation as described in Section 1797.105(c) of Division 2.5 of the Health and Safety Code to:

(1) Sustain the determination of the authority, or

(2) Overrule the determination of the authority and permit local implementation of the plan.

(d) Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of the proposed decision at the next regularly scheduled Commission meeting.

PROPOSED

26 (e) The Commission shall permit Public comment pursuant to the Bagley-Keene Open
27 Meeting act. The Commission shall not accept new evidence at the meeting, but shall
28 rely solely on the evidence of record at the administrative hearing.
29 (f) The Commission's vote on the proposed decision is limited to the following:
30 (1) adopt the administrative law judge's proposed decision, or
31 (2) not adopt the administrative law judges proposed decision, or
32 (3) return the proposed decision to the office of Administrative Hearings for re-hearing if
33 the proposed decision is inconsistent with this article or statute or regulations.
34 (g) The decision by the Commission shall be by simple majority vote of a quorum of
35 those members present at the meeting where the proposed decision is scheduled as an
36 agenda item.
37 (h) The decision of the Commission is final.
38 (i) Pursuant to California Code of Regulations Title 1, Section 1042, the prevailing party
39 may recover costs.
40
41 Authority: Section 1797.107 of the Health and Safety Code
42 Reference: Sections 1797.105 and 254
43

PROPOSED

COMMENTS for APPEALS PROCEEDINGS TO THE COMMISSION REGULATIONS, CHAPTER 13, Section 100450.100
Comment Period: March 13, 2015 – April 27, 2015

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

EDMUND G. BROWN JR., *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

DATE: March 12, 2015

TO: Commission on EMS
Other Interested Parties

FROM: Howard Backer, MD, MPH, FACEP
Director

Daniel R. Smiley for

PREPARED BY: Tom McGinnis, EMT-P
Chief, EMS Systems Division

SUBJECT: EMS Plan Appeal Emergency Regulations Update

The EMS Authority has withdrawn the request for the EMS Plan Appeal emergency Regulations from the Office of Administrative Law (OAL) on March 12, 2015.

The decision to withdraw these regulations was based on technical assistance given to the EMS Authority from OAL relating to strength of justification of an emergency need for these regulations, timing of OAL approval and subsequent Commission on EMS meeting, and potential changes to the text of the regulations that OAL would recommend. The voluntary withdrawal provides greater flexibility for potential re-submission of an emergency regulations packet, subsequent to further discussion with the Commission.

This issue is on the agenda for the March 18, 2015 Commission on EMS meeting where there will be the opportunity for discussion on the decision to withdraw the request for approval of the emergency EMS Plan Appeal Regulations, and if a re-submission of the emergency regulations packet is desired.

This does not affect the public comment process for the regulations that are following the regular rulemaking process. The public comment period for these regulations begin Friday, March 13, 2015. The Commission will also have an agenda item to discuss the regular EMS Plan Appeal regulations at the EMS Commission meeting on March 18, 2015 in Los Angeles.

TITLE 22. SOCIAL SECURITY
DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES
CHAPTER 1.9 LAY RESCUER EPHINEPHRINE AUTO-INJECTOR TRAINING CERTIFICATION STANDARDS
[Notice published on March 6, 2015]

NOTICE OF PROPOSED RULEMAKING

The Emergency Medical Services Authority ("EMSA") proposes to adopt regulations described below after considering all comments, objections, and recommendations regarding the proposed action.

PUBLIC HEARING

EMSA will hold a public hearing on April 21, 2015. The hearing will begin at 10:00 am and end at 12:00 pm. The location of the public hearing is: 10901 Gold Center Drive, Suite 400, Rancho Cordova, CA 95670. EMSA requests that persons making oral comments at the hearing also submit a written copy of their testimony at the hearing.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the EMSA. Comments may also be submitted by facsimile (FAX) at (916) 324-2875 or by e-mail to corrine.fishman@emsa.ca.gov. The written comment period closes at **5:00 p.m.** on April 20, 2015. The EMSA will consider only comments received at the EMSA offices by that time. Submit comments to:

Corrine Fishman, Program Analyst
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

AUTHORITY AND REFERENCE

The EMSA proposes to add Chapter 1.9 to Division 9, of Title 22.
The Health and Safety Code, Section 1797.107 authorizes the EMSA to adopt the proposed regulations, which would implement, interpret, or make specific Section 1797.197a of the Health and Safety Code.

INFORMATIVE DIGEST/ POLICY STATEMENT OVERVIEW

Senate Bill 669 (Chapter 725, Statutes of 2013), requires the EMSA to adopt minimum standards for training and certification of prehospital emergency medical care persons and lay rescuers in the use and administration of the epinephrine auto-injector to render emergency care to another person as defined in Section 1797.197a of the Health and Safety Code. The statute also directs the EMSA to adopt reasonable fees for review and approval of epinephrine auto-injector training programs and establishes the Specialized First Aid Training Program Approval Fund into which these fees shall be deposited.

This rulemaking action clarifies and makes specific the minimum training and certification standards and requirements for the use and administration of epinephrine auto-injectors.

The regulations proposed in this rulemaking action intend to: Establish the procedures required to become an EMSA approved training program; specify subject matter areas that must be covered by a training program; specify requirements of a program director or instructor; specify the notification process for program approval and withdrawal and specify all fees. The regulations will also specify the certification requirements, application of training and fees required for a lay person to be certified to use and administer an epinephrine auto-injector.

Anticipated Benefits of the Proposed Regulation:
The broad objective of the regulation is anticipated to provide the lay person training in the use and administration of an epinephrine auto-injector. The specific benefit from the regulation is to protect the health and safety of the public by allowing the lay person, who meets the prescribed qualifications, to use and administer an epinephrine auto-injector to any person suffering from an allergic emergency while also providing civil liability protection.

Determination of Inconsistency/Incompatibility with Existing State Regulations:
EMSA has determined that this proposed regulation is not inconsistent or incompatible with existing regulations. After conducting a review for any regulations that would relate to or affect this area, EMSA has concluded that these are the only regulations that concern the use and administration of an epinephrine auto-injector by a lay person.

DISCLOSURES REGARDING THE PROPOSED ACTION

The EMSA has made the following initial determinations:

- Mandate on local agencies and school districts: None
- Cost or savings to any state agency: None

- Cost to any local agency or school district which must be reimbursed in accordance with Government Code Sections 17500 through 17630: None

- Other nondiscretionary cost or savings imposed on local agencies: None

- Cost or savings in federal funding to the state: None

- Cost impacts on a representative private person or business: There will be a cost to a private person representing the cost of the training course and the cost of the epinephrine auto-injector. Because this training is not required, there is no obligation that any individual should incur these costs. There will be administrative costs for a business that chooses to develop a course of training as prescribed by these regulations.

- Significant, statewide adverse economic directly impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None.

- Significant effect on housing costs: None

- The proposed regulations may affect small businesses.

Results of the Economic Impact Analysis/Assessment
The EMSA concludes that it is (1) unlikely that the proposal will eliminate any jobs public safety personnel or epinephrine training providers, (2) likely that the proposal will create an unknown number of jobs for providers of epinephrine auto-injector training, (3) likely that the proposal will create an unknown number of new businesses providing training in epinephrine auto-injector use and administration, (4) unlikely that the proposal will eliminate any existing businesses, and (5) unlikely that the proposed regulations will result in the expansion of businesses currently doing business within the state.

Benefits of the Proposed Action: The proposed regulations will benefit California residents by allowing a person suffering an allergic emergency to receive potentially lifesaving medical care by providing the lay person with a process to obtain a prescription for an epinephrine auto-injector that they may use and administer to any person in an allergic emergency situation. The regulations also increase public safety by specifying the minimum training standards and requirements to be met in order to use and administer an epinephrine auto-injector.

CONSIDERATION OF ALTERNATIVES

In accordance with Government code section 11346.5, subdivision (a)(13), EMSA must determine that no reasonable alternative it considered or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

EMSA invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

CONTACT PERSONS

Inquiries concerning the proposed administrative action may be directed to:

Corrine Fishman, program analyst
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670
(916) 431-3727
Corrine.fishman@emsa.ca.gov

The backup contact person for these inquiries is:

Alternate Contact Person:
Lisa Witchey, Manager
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670
Lisa.witchey@emsa.ca.gov

Please direct requests for copies of the proposed text (the "express terms") of the regulations, the initial statement of reasons, the modified text of the regulations, if any, or other information upon which the rulemaking is based to Corrine Fishman at the above address.

AVAILABILITY OF STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, AND RULEMAKING FILE

The EMSA will have the entire rulemaking file available for inspection and copying throughout the rulemaking process at its office at the above address. As of the date this notice is published in the Notice Register, the rulemaking file consists of this notice, the proposed text of the regulations, and the initial

statement of reasons. Copies may be obtained by contacting Corrine Fishman at the address or phone number listed above.

AVAILABILITY OF CHANGED OR MODIFIED TEXT

After holding the hearing and considering all timely and relevant comments received, the EMSA may adopt the proposed regulations substantially as described in this notice. If the EMSA makes modifications which are sufficiently related to the originally proposed text, it will make the modified text (with the changes clearly indicated) available to the public for at least 15 days before the EMSA adopts the regulation as revised. Please send requests for copies of the modified regulations to the attention of Corrine Fishman at the address indicated on the previous page. The EMSA will accept written comments on the modified regulations for 15 days after the date on which they were made available.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, copies of the Final Statement of Reasons may be obtained by contacting Corrine Fishman at the address listed on the previous page.

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Action, the Initial Statement of Reasons, and the text of the regulations in underline and strikeout can be accessed through our website at www.emsa.ca.gov.

The PES – Crisis Stabilization and Evaluation for All
Regional Dedicated Psychiatric Emergency Services (PES)
Dedicated Psychiatric/Substance Use Disorder Emergency Department

Too often, individuals with urgent mental health needs have no alternative but to go to medical emergency rooms (ER) at hospitals, where there can be few staff trained in mental health, the environment is not conducive to healing, and there may be little alternatives for disposition but psychiatric hospitalization.

The vast majority of individuals in mental health crisis who arrive at a hospital emergency department are placed on an involuntary LPS 5150 police detainment order and brought to a hospital by law enforcement or emergency transportation vehicles. The method by which an individual is placed on an LPS 5150 detainment and subsequently transported varies by county. There is also wide variation on whether a law enforcement officer physically stays with the individual detained on an LPS 5150 once they arrive at a hospital emergency department.

Unfortunately, there are no local or statewide mechanisms to track the number of LPS 5150 detainment orders written, nor is there a way to determine how many of the LPS 5150s are evaluated under LPS 5151and upheld for detainment. This also holds true for determining the number of individuals who ultimately are involuntarily committed on an LPS 5152, 72-hour hold. It is estimated that a minimum of 300,000 individuals are on 5150 detainment in hospital emergency departments annually. It is also estimated that at least 210,000 (70%) of these 300,000 individuals did not meet the criteria for inpatient admission under the LPS 5152, 72-hour involuntary hold criteria.

A Psychiatric Emergency Services (PES) unit is a far better alternative for people in crisis. A PES can be located on a hospital campus or in the community, but even when on the hospital grounds, the PES interior is far more calming and welcoming than a medical ER. PES layouts typically have décor, lighting, sound/music, and open spaces designed with the goal of encouraging healing and recovery, which make them quite different from a hectic, antiseptic medical ER with its noisy machinery and frightening equipment.

PES programs are designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance abuse crisis, and strive to stabilize consumers on site and avoid psychiatric hospitalization whenever possible. A PES provides emergency/urgent walk-in and police-initiated evaluation and crisis phone service 24 hours a day, 7 days a week.

A PES provides complete evaluation and treatment for all who present, regardless of level of acuity or insurance status. PES programs do not have "exclusion" or "no-admit" lists which prevent certain patients from entering their facility. Rather, a PES will work with everyone in need, following "Zeller's Six Goals of Emergency Psychiatric Care":

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion

- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

As studies have estimated as many as 20-30% of psychiatric emergencies may be due to, or are combined with, serious medical concerns, it is important that all crisis patients receive an appropriate medical screening. Next, all efforts are made to stabilize or reduce the symptoms that are causing a person distress – be they suicidal thoughts, auditory hallucinations, severe paranoia, mania, or other difficult conditions. Whenever possible, all evaluation and treatment is done free of coercion, with staff forming a therapeutic, collaborative partnership with each consumer. Treatment is done in the least restrictive setting, so restraints and/or seclusion are to be avoided, and consumers should be returned to their home or freedom in the community as soon as possible. All who leave the PES should have a solid aftercare plan including follow-up appointments, medication information, and strategies to help the person avoid crises in the future.

A typical dedicated PES department meets all these goals, and is staffed with psychiatric physicians and mental health professionals around the clock who can provide:

- Screening for all emergency medical conditions and provide basic primary medical care (e.g., oral alcohol withdrawal, asthma, diabetes management, pain, continuation of outpatient medications)
- medication management
- laboratory testing services
- psychiatric evaluation/assessment for voluntary and involuntary treatment
- treatment with observation and stabilization capability on site
- crisis intervention and crisis stabilization
- screening for inpatient psychiatric hospitalization
- linkage with resources and mental health and substance abuse treatment referral information

A PES can dramatically improve access to care and quality of care while decreasing costs to the health care delivery system. Today, in communities without a PES, patients are taken to traditional hospital emergency rooms and often languish with no psychiatric assistance or intervention for hours, sometimes days, awaiting the arrival of an individual trained to provide a psychiatric assessment or an available inpatient psychiatric bed. This, in and of itself, undermines the formation of a positive therapeutic alliance for the patient, delays treatment for the patient, ties up staff time and an ER bed in an already overburdened medical emergency department. Unfortunately, for safety reasons, too often patients are placed in restraints, with a sitter, or both, if considered a danger to themselves or others.

A 2009 survey of Medical Directors of medical emergency departments in hospitals across the U.S. called for Regional Dedicated Psychiatric Emergency Programs as a potential solution to the major national problems of psychiatric patients boarding for long hours in emergency departments. Indeed, a recent study showed that a PES in a system decreased boarding times

over 80% compared to overall California boarding times, and led to stabilization and discharge without needing inpatient admission over 75% of the time.

The ability of a PES to avoid hospitalization for the vast majority of patients is due to being able to treat patients for up to 23 hours and 59 minutes (thus sometimes referred to as "23-hour treatment facilities"). This permits time for treatment, observation and "healing time," which is often sufficient to stabilize patients' symptoms so they can return home or to another less-restrictive level of care. This follows a simple truth, that most patients in psychiatric crisis do not need hospitalization, though they do need urgent intervention and care.

The goals of healthcare reform include improved access to care, improved quality of care, improved timeliness of care, along with less hospital admissions and reduced costs. Adding a PES to appropriate systems helps to meet all these goals.

To standardize definitions, the key concept that differentiates a true PES from what are more often called crisis stabilization units, crisis clinics, etc., is that a true PES is a program separately housed from a medical hospital ED (i.e., not considered to be just a wing of a larger ED) that can take ambulance/police deliveries independently from the field. This makes it different from the typical Crisis Stabilization Unit, which usually evaluates and treats patients who have already been initially received and medically screened in a medical ED, then transfers over when considered medically stable. However, both programs do what is basically called "Crisis Stabilization," and there are so many variations in design that difference in these programs can be minimal.

The concept of a PES being a "dedicated emergency department" comes from EMTALA law:

> "A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions."

A PES is not a "medical emergency department," nor a "community clubhouse model," but a blend of both, which is community-based and uses the Recovery Model concept.

In California, there are at least 10 PES departments operating in seven counties. There may be other comparable facilities or programs as well. The current PES departments are:

1. Alameda Health System, Oakland
2. Contra Costa County Regional Medical Center
3. Los Angeles County (Harbor-UCLA Medical Center, LAC+USC Medical Center and Olive View Medical Center)
4. Marin County
5. San Francisco General Hospital
6. San Mateo County
7. Valley Hospital (Santa Clara County)
8. One under construction in Ventura County

There is a need for at least an additional ten PES units; see attached map.

Psychiatric Emergency Services (PES) vs. Crisis Stabilization Unit (CSU)

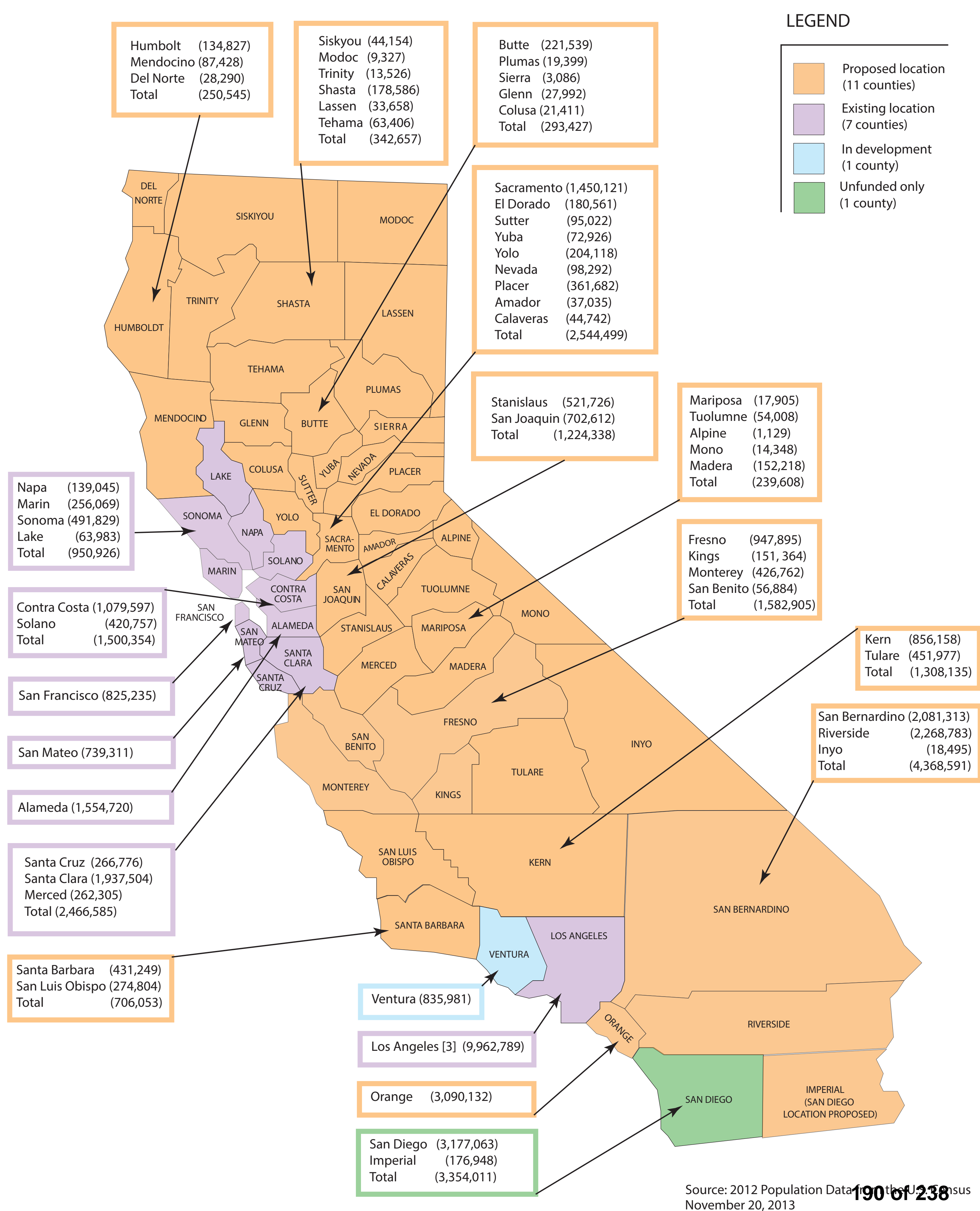
<table>
<tr><th>Psychiatric Emergency Department</th><th>Proposed Blended Model Emergency Treatment Services</th><th>Crisis Stabilization Unit</th></tr>
<tr><td>Operates as an active Treatment Model and services are available 24/7 and no one is restricted from using the service as it falls under EMTALA rules as patients are seen as having an “Emergency Medical Condition”</td><td>Open 24/7</td><td>Provides Triage and limited treatment, assessment for starting or discontinuing a hold and referral services. A psychiatrist is the lead clinician either in person or via telepsychiatry – may not be available 24/7</td></tr>
<tr><td>Open with physician available 24/7</td><td>Medical staff available 24/7 including telepsychiatry services</td><td>Not open 24/7 or have physician present</td></tr>
<tr><td>Capacity to screen for all “Emergency Medical Conditions”</td><td>Capacity to screen for all “Emergency Medical Conditions”</td><td>Does not have capacity to screen for all “Emergency Medical Conditions”</td></tr>
<tr><td>Has contracts for payment with plans</td><td>Contracts for payment with plans</td><td>Does not typically contract with plans</td></tr>
<tr><td>Qualifies under EMTALA</td><td>EMTALA qualification to be determined</td><td>Does not qualify as EMTALA provider</td></tr>
<tr><td>Required to assess all who present</td><td rowspan="4">Required to treat all individuals, regardless of payment or legal status (voluntary and involuntary)</td><td>Can be selective about patients served</td></tr>
<tr><td>Can bill Medicare ($117 per hour up to 20)</td><td>Cannot bill Medicare</td></tr>
<tr><td>Can bill under Medi-Cal Waiver ($90+ hr.)</td><td>Can bill under Medi-Cal Waiver ($90+hr.)</td></tr>
<tr><td>Do not maintain “Do not admit lists”</td><td>May maintain a “Do not drop off list”</td></tr>
<tr><td>Law enforcement drop-offs allowed</td><td>Drop-off by EMS, law enforcement, family, friend, or self</td><td>No 5150 law enforcement drop offs</td></tr>
<tr><td>Typically located on hospital grounds</td><td>May be located on hospital grounds or in the community</td><td>May be located on hospital grounds or in the community</td></tr>
</table>

Regulations:

Residential Treatment: Welfare & Institutions Code §5671

Crisis Stabilization: Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, §1810.210

Proposed and Existing Psychiatric Emergency Services (PES) and Service Areas in California (with population)



Source: 2012 Population Data from the U.S. Census
November 20, 2013

ASSEMBLY BILL No. 1300

Introduced by Assembly Member Ridley-Thomas

February 27, 2015

An act to amend Sections 5001, 5008, 5013, 5150, 5150.05, 5150.1, 5150.2, 5151, 5152.1, 5153, and 5270.50 of, to add Sections 5001.5, 5022, 5023, 5024, 5025, 5026, 5150.3, 5151.1, and 5151.2 to, to add the heading of Article 1.3 (commencing with Section 5151) to, to add Article 1.1 (commencing with Section 5150.10) to, to add Article 1.2 (commencing with Section 5150.30) to, Chapter 2 of Part 1 of Division 5 of, to repeal Section 5150.4 of, and to repeal and add Section 5152.2 of, the Welfare and Institutions Code, relating to mental health.

legislative counsel's digest

AB 1300, as introduced, Ridley-Thomas. Mental health: involuntary commitment.

Under existing law, when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county and approved by the State Department of Health Care Services as a facility for 72-hour treatment and evaluation.

This bill would authorize counties to designate one or more persons to act as a local or regional liaison to assist a person who is a patient in an emergency department of a defined nondesignated hospital and who has been detained, or who may require detention, for evaluation and treatment, as specified. The bill would reorganize and make changes

to the provisions relating to the detention for evaluation and treatment of a person who may be subject to the above provisions, including specifying procedures for delivery of those individuals to various facilities; evaluation of the person for probable cause for detention for evaluation and treatment; terms and length of detention, where appropriate, in various types of facilities; and criteria for release from defined designated facilities and nondesignated hospitals. The bill would authorize a provider of ambulance services to transfer a person who is voluntarily transferring to a designated facility for evaluation and treatment. The bill would also make changes to the methods by which law enforcement is notified of the release of a person detained for evaluation and treatment.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 5001 of the Welfare and Institutions Code
2 is amended to read:
3 5001. The provisions of this part and Part 1.5 (commencing
4 with Section 5585) shall be construed to promote the legislative
5 intent as follows:
6 (a) To end the inappropriate, indefinite, and involuntary
7 commitment of persons with mental health disorders,
8 developmental disabilities, and chronic alcoholism, and to eliminate
9 legal disabilities.
10 (b) To provide prompt evaluation and treatment of persons with
11 mental health disorders or impaired by chronic alcoholism.
12 (c) To guarantee and protect public safety.
13 (d) To safeguard individual rights through judicial review.
14 (e) To provide individualized treatment, supervision, and
15 placement services by a conservatorship program for persons who
16 are gravely disabled.
17 (f) To encourage the full use of all existing agencies,
18 professional personnel, and public funds to accomplish these
19 objectives and to prevent duplication of services and unnecessary
20 expenditures.
21 (g) To protect persons with mental health disorders and
22 developmental disabilities from criminal acts.

(h) To provide consistent standards for protection of the personal rights of persons receiving services under this part and under Part 1.5 (commencing with Section 5585).

(i) To provide services in the least restrictive setting appropriate to the needs of each person receiving services under this part and under Part 1.5 (commencing with Section 5585).

(j) To ensure that persons receive services from facilities and providers that are qualified and best suited to provide the services, and that persons are not detained in settings that are not therapeutic or not designed to meet their needs.

(k) To affirm that no person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether that evaluation or treatment was voluntarily or involuntarily received.

SEC. 2. Section 5001.5 is added to the Welfare and Institutions Code, to read:

5001.5. It is the intent of the Legislature that each county shall have the responsibility to ensure that all persons with mental disorders who are subject to detention under this part or under Part 1.5 (commencing with Section 5585) receive prompt evaluation and treatment in accordance with this part and Part 1.5 (commencing with Section 5585), including prompt assessment of the need for evaluation and treatment. It is the intent of the Legislature that each county establish and maintain a mental health service system that has sufficient capacity to ensure the provision of services under this Part and Part 1.5 (commencing with Section 5585), including, at a minimum, the services required under paragraph (2) of subdivision (a) of Section 5651.

SEC. 3. Section 5008 of the Welfare and Institutions Code is amended to read:

5008. Unless the context otherwise requires, the following definitions shall govern the construction of this part:

~~(a) "Evaluation" consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees of an agency providing face-to-face, which includes telehealth, evaluation services or may be part-time employees or may be employed on a contractual basis.~~

(a) "Antipsychotic medication" means medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders.

(b) "Application for detention for evaluation and treatment" means the written application set forth in Section 5150.3.

(c) (1) "Assessment" means the determination, as described in subdivision (b) of Section 5150 and Section 5151, of the following:

(A) Whether the person meets the criteria for detention for evaluation and treatment.

(B) Whether the person is in need of evaluation and treatment and, if so, what services are needed for the person.

(C) Whether the person can be properly served without being detained, in which case the services shall be provided on a voluntary basis.

(2) "Assessment" includes, but is not limited to, mental status determination, analysis of clinical and social history, analysis of relevant cultural issues and history, diagnosis, and the use of testing procedures.

(d) "Authorized professional" means any of the following:

(1) A person or category of persons, excluding peace officers, who are authorized in writing by a county to provide services described in Article 1 (commencing with Section 5150) of Chapter 2, including a probable cause determination for the detention of a person for evaluation and treatment under Section 5150 and the release of a person from detention for evaluation and treatment under Section 5150.15.

(2) An authorized member of the professional staff of a facility.

(3) An authorized member of a mobile crisis team.

(e) "Conservatorship investigation" means an investigation, by an agency appointed or designated by the governing body, of cases in which conservatorship is recommended pursuant to Chapter 3 (commencing with Section 5350).

(f) "Court," unless otherwise specified, means a court of record.

~~(b)~~

(g) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Article 2 (commencing with Section 5200) or by a superior court pursuant to Article 3 (commencing with Section 5225) of Chapter 2.

~~(c)~~

(h) “Crisis intervention” consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services.

~~(f) “Prepetition screening” is a screening of all petitions for court-ordered evaluation as provided in Article 2 (commencing with Section 5200) of Chapter 2, consisting of a professional review of all petitions; an interview with the petitioner and, whenever possible, the person alleged, as a result of a mental health disorder, to be a danger to others, or to himself or herself, or to be gravely disabled, to assess the problem and explain the petition; when indicated, efforts to persuade the person to receive, on a voluntary basis, comprehensive evaluation, crisis intervention, referral, and other services specified in this part.~~

~~(g) “Conservatorship investigation” means investigation by an agency appointed or designated by the governing body of cases in which conservatorship is recommended pursuant to Chapter 3 (commencing with Section 5350).~~

(i) “Crisis stabilization service or unit” means an ambulatory service that provides probable cause determinations and assessments, collateral services, and therapy within the scope of its designation under this part.

(j) “Department” means the State Department of Health Care Services.

(k) (1) “Designated facility” means a facility or a specific unit or part of a facility that is licensed or certified as a mental health evaluation facility, a mental health treatment facility, or a mental health evaluation and treatment facility. A designated facility may be an inpatient facility or an ambulatory facility.

(2) “Inpatient facility” means a health facility, or an inpatient unit of a health facility, as defined in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, that is

licensed and has the capability to admit and treat persons on an inpatient basis subject to the requirements of this part. A designated inpatient facility includes any of the following:

(A) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(B) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(C) A psychiatric health facility, as defined in Section 1250.2 of the Health and Safety Code.

(3) "Ambulatory facility" means a facility or other provider designated by a county under Section 5023 that provides psychiatric services lasting less than 24 hours in accordance with applicable law and within the scope of the designation. An ambulatory facility may include an outpatient hospital department, clinic, crisis stabilization service or unit, medical group, facility of a provider organization other than a medical group, or other facility that meets the requirements established by the department in accordance with Section 5023.

(l) "Detained for evaluation and treatment" and "detention for evaluation and treatment" mean the taking into custody and detention of a person in accordance with Section 5150.

(m) "Emergency" means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

(n) "Emergency transport provider" means a provider of ambulance services licensed by the Department of the California Highway Patrol or operated by a public safety agency and includes the authorized personnel of an emergency transport provider who are certified or licensed under Sections 1797.56, 1797.80, 1797.82, and 1797.84 of the Health and Safety Code.

(o) "Evaluation" means a multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees or independent contractors of a county, designated facility, or other

agency providing face-to-face evaluation services, which includes telehealth.

~~(h)~~

(p) (1) For purposes of Article 1 (commencing with Section 5150), Article 2 (commencing with Section 5200), and Article 4 (commencing with Section 5250) of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means either of the following:

(A) A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

(B) A condition in which a person, has been found mentally incompetent under Section 1370 of the Penal Code and all of the following facts exist:

(i) The indictment or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.

(ii) The indictment or information has not been dismissed.

(iii) As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.

(2) For purposes of Article 3 (commencing with Section 5225) and Article 4 (commencing with Section 5250), of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means a condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

(3) The term "gravely disabled" does not include persons with intellectual disabilities by reason of that disability alone.

(q) "Intensive treatment" consists of hospital and other services as may be indicated. Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the California Medical Assistance Program (Medi-Cal) set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, or under Title XVIII of the federal Social Security Act and regulations thereunder. Intensive treatment may be provided in hospitals of the United States government by properly qualified professionals.

1 *Nothing in this part shall be construed to prohibit an intensive*
2 *treatment facility from also providing 72-hour evaluation and*
3 *treatment.*
4 *(r) "Local or regional liaison" means a person or persons*
5 *authorized by a county, or by two or more counties acting jointly,*
6 *under Section 5024.*
7 *(s) "Mobile crisis team" means a team comprised of one or*
8 *more professionals, and which may also include peer counselors,*
9 *who are authorized by a county to provide probable cause*
10 *determinations and other services under this part.*
11 ~~(i)~~
12 *(t)* "Peace officer" means a duly sworn peace officer as that
13 term is defined in Chapter 4.5 (commencing with Section 830) of
14 Title 3 of Part 2 of the Penal Code who has completed the basic
15 training course established by the Commission on Peace Officer
16 Standards and Training, or any parole officer or probation officer
17 specified in Section 830.5 of the Penal Code when acting in relation
18 to cases for which he or she has a legally mandated responsibility.
19 ~~(j)~~
20 *(u)* "Postcertification treatment" means an additional period of
21 treatment pursuant to Article 6 (commencing with Section 5300)
22 of Chapter 2.
23 *(v) "Prepetition screening" is a screening of all petitions for*
24 *court-ordered evaluation as provided in Article 2 (commencing*
25 *with Section 5200) of Chapter 2, consisting of a professional review*
26 *of the petition; an interview with the petitioner and, whenever*
27 *possible, the person alleged, as a result of a mental health disorder,*
28 *to be a danger to others, or to himself or herself, or to be gravely*
29 *disabled, to assess the problem and explain the petition; and when*
30 *indicated, efforts to persuade the person to receive, on a voluntary*
31 *basis, comprehensive evaluation, crisis intervention, referral, and*
32 *other services specified in this part.*
33 *(w) "Probable cause determination" means a determination*
34 *whether there is probable cause for the detention of a person for*
35 *evaluation and treatment.*
36 *(x) "Professional person in charge of a facility" means the*
37 *licensed person authorized by a designated facility who is*
38 *responsible for the clinical direction of the designated facility.*
39 *(y) "Professional staff" means the medical staff or other*
40 *organized professional staff of an inpatient facility.*

(z) “Referral” means referral of persons by each facility, provider, or other organization providing assessment, evaluation, crisis intervention, or treatment services to other facilities, providers, or agencies in accordance with Section 5013 and Part 1.5 (commencing with Section 5585).

(aa) “Telehealth” means the telehealth services, as defined in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code, for the purpose of providing services under this part, including a probable cause determination, the release of a person from detention for evaluation and treatment under Section 5150.15, assessment or evaluation, and treatment. For purposes of this part, telehealth services may be used by any licensed professional, including a psychologist, clinical social worker, and other mental health professional, acting within the scope of his or her profession for providing evaluation, treatment, consultation, or other mental health services under this part.

SEC. 4. Section 5013 of the Welfare and Institutions Code is amended to read:

5013. (a) ~~It~~ *The purpose of a referral shall be to provide for continuity of care. A referral may include, but need not be limited to, informing the person of available services, making appointments on the person’s behalf, communication with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for escort, transportation, or both, when necessary. A referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services. All persons shall be advised of available precare services that prevent initial recourse to hospital treatment or aftercare services that support adjustment to community living following hospital treatment. These services may be provided through county or city mental health departments, state hospitals under the jurisdiction of the State Department of State Hospitals, regional centers under contract with the State Department of Developmental Services, or other public or private entities.*

(b) It is the intent of the Legislature that referrals between facilities, providers, and other organizations shall be facilitated by the sharing of information and records in accordance with Section 5328 and applicable federal and state laws.

~~(b)~~

(c) Each city or county ~~mental~~ *behavioral* health department is encouraged to include on its Internet Web site a current list of ambulatory *behavioral health* services and other resources for persons with ~~mental~~ *behavioral* health disorders and substance use disorders in the city or county that may be accessed by providers and consumers of ~~mental~~ *behavioral* health services. The list of services on the Internet Web site should be updated at least annually by the city or county ~~mental~~ *behavioral* health department.

SEC. 5. Section 5022 is added to the Welfare and Institutions Code, to read:

5022. The department shall promote the consistent statewide application of this part in order to ensure protection of the personal rights of all persons who are subject to this part and Part 1.5 (commencing with Section 5585). The department shall provide oversight of the statewide application of this part and facilitate discussion among the organizations listed in subdivision (a) of Section 5400, law enforcement agencies, hospitals, mental health professionals, county patients' rights advocates, and other stakeholders as may be necessary or desirable to achieve the legislative intent of consistent statewide application. These discussions shall include situations where persons are certified for additional intensive treatment in a county authorizing that treatment under Article 4.7 (commencing with Section 5270.10) of Chapter 2 who are then transferred to a facility during the course of additional intensive treatment in a county that has not authorized additional intensive treatment.

SEC. 6. Section 5023 is added to the Welfare and Institutions Code, to read:

5023. (a) Each county may designate facilities within the county, with the approval by the department, that meet the applicable requirements established by the department by regulation.

(b) (1) Each county may designate ambulatory facilities within the county that meet the behavioral health needs of persons within the requirements of applicable law and the scope of their designation. The department shall encourage counties to use appropriate ambulatory facilities for the evaluation and treatment of persons pursuant to this part.

(2) Counties, mental health professionals, providers, and other organizations, with the support of the department, are encouraged

to establish crisis stabilization services and other ambulatory facilities that are designated by a county to provide probable cause determinations and assessments, and, as applicable, evaluation and treatment services and crisis stabilization services, in settings that are appropriate to the needs of persons with severe mental illness and less restrictive than inpatient health facilities.

(3) Nothing in this subdivision shall preclude the designation of an ambulatory facility that is an outpatient clinic of a licensed health facility.

(4) An ambulatory facility shall provide services within the scope of its designation to all persons regardless of their place of residence.

(c) Regulations adopted pursuant to this part establishing staffing standards for designated facilities shall be consistent with applicable licensing regulations for the type of facility. If there are no licensing regulations for the type of designated facility, or for certain categories of professional personnel providing services in a type of designated facility, the regulations adopted pursuant to this part for staffing standards may differentiate between the types of designated facilities, including ambulatory facilities. On January 1, 2016, the existing regulations establishing staffing standards for designated facilities set forth in Section 663 of Title 9 of the California Code of Regulations are repealed and nullified.

(d) A county may contract with a facility or other provider in an adjacent state that, within the discretion and oversight of the county, will meet the needs of county residents under this part and that has agreed in writing to meet the terms and conditions established by the county for the scope of services to be performed by the facility or other provider. The terms and conditions shall include the protection of a person's rights under Article 7 (commencing with Section 5325) of Chapter 2 and access to persons placed in the facility by patients' right advocates of the contracting county.

(e) A county shall not charge or assess a fee for the designation of an ambulatory facility or the approval of an authorized professional.

(f) Each designated facility shall accept, within its clinical capability and capacity, all categories of persons for whom it is designated, without regard to insurance or financial status. If a person presents to a designated facility with a psychiatric

1 emergency medical condition, as defined in subdivision (f) of
2 Section 5150.10, that is beyond its capability, the facility shall
3 assist the person in obtaining emergency services and care at an
4 appropriate facility.
5 (g) In order to provide access by members of the public to
6 information about designated facilities, each county department
7 responsible for mental health services shall maintain on its Internet
8 Web site the locations of all designated facilities within the county,
9 including address, the types of services available at each designated
10 facility, and the hours of operation for ambulatory facilities. The
11 Internet Web site shall be updated if there are changes to the
12 information.
13 (h) Each county shall report to the department, on at least an
14 annual basis, a current list of designated facilities within the county,
15 including the name and address of each facility and its facility
16 type. The department shall maintain a list of designated facilities,
17 by county and facility licensure type, on its Internet Web site, and
18 update the list not less than annually. The department Internet Web
19 site shall also contain links to each county Internet Web site
20 required by subdivision (g).
21 (i) Counties are encouraged to share information with adjacent
22 and other counties with respect to its roster of authorized
23 professionals. An authorized professional shall not be required to
24 obtain approval from another county to be an authorized
25 professional in that county in order to take action under this part.
26 SEC. 7. Section 5024 is added to the Welfare and Institutions
27 Code, to read:
28 5024. (a) Each county may authorize one or more qualified
29 persons to act as a local or regional liaison to assist nondesignated
30 hospitals in the county in accordance with this section and Article
31 1.1 (commencing with Section 5150.10) of Chapter 2. Two or
32 more counties may enter into an inter-county arrangement under
33 which the participating counties agree to authorize one or more
34 persons to act as a local or regional liaison to assist nondesignated
35 hospitals in the participating counties in accordance with this
36 section and Article 1.1 (commencing with Section 5150.10) of
37 Chapter 2.
38 (b) The role of the local or regional liaison is to assist a person
39 who is a patient in an emergency department of a nondesignated
40 hospital and who has been detained, or may require detention, for

1 evaluation and treatment. The assistance may include any of the
2 following:
3 (1) Arranging for an authorized professional to provide a prompt
4 probable cause determination under Section 5150.13.
5 (2) Arranging for an authorized professional to determine
6 whether the detention for evaluation and treatment of a person
7 shall be released under Section 5150.15.
8 (3) Arranging for the placement of a person detained for
9 evaluation and treatment who is medically clear for transfer or
10 discharge to a designated facility.
11 (c) A local or regional liaison may be employed by, or may
12 contract with, a county or counties and may include personnel of
13 one or more designated facilities within the county or counties.
14 The role of the local or regional liaison may be rotated among the
15 categories of persons described in this subdivision.
16 (d) A local or regional liaison shall be available 24 hours a day,
17 including weekends and holidays, to provide assistance under this
18 section.
19 (e) Each county, or counties acting jointly under this section,
20 shall provide the nondesignated hospitals in the county or counties
21 with the contact information for a local or regional liaison. The
22 means of contact may be a designated telephone number, email,
23 text-messaging or other electronic means, or any combination of
24 the foregoing, so long as the local or regional liaison has immediate
25 access to the means of contact. The contact information provided
26 to nondesignated hospitals shall be updated as necessary.
27 (f) This section shall not apply to a county that has not
28 authorized a local or regional liaison.
29 SEC. 8. Section 5025 is added to the Welfare and Institutions
30 Code, to read:
31 5025. (a) A designated facility or nondesignated hospital, as
32 defined in subdivision (e) of Section 5150.10, or a physician,
33 employee, or other staff person acting within the scope of his or
34 her official duties or employment for the designated facility or
35 nondesignated hospital shall not be liable for any injury resulting
36 from determining any of the following:
37 (1) Whether to detain a person for a mental health disorder or
38 addiction, in accordance with this part.

1 (2) The terms, conditions, and enforcement of detention for a
2 person with a mental health disorder or addiction, in accordance
3 with this part.
4 (3) Whether to release a person detained for a mental health
5 disorder or addiction, in accordance with this part.
6 (b) A physician, employee, or other staff person acting within
7 the scope of his or her official duties or employment for a
8 designated facility or nondesignated hospital shall be not liable
9 for carrying out a determination described in subdivision (a) so
10 long as he or she uses due care.
11 (c) Nothing in this section shall exonerate a physician, employee,
12 or other staff person acting within the scope of his or her official
13 duties or employment for a designated facility or nondesignated
14 hospital from liability for injury proximately caused by his or her
15 negligent or wrongful act or omission in carrying out or failing to
16 carry out any of the following:
17 (1) A determination to detain or not to detain a person for a
18 mental health disorder or addiction, in accordance with this part.
19 (2) The terms or conditions of detention of a person for a mental
20 health disorder or addiction, in accordance with this part.
21 (3) A determination to release a person detained for a mental
22 health disorder or addiction, in accordance with this part.
23 SEC. 9. Section 5026 is added to the Welfare and Institutions
24 Code, to read:
25 5026. (a) A designated facility or nondesignated hospital, as
26 defined in subdivision (e) of Section 5150.10, or a physician,
27 employee, or other staff person acting within the scope of his or
28 her official duties or employment for the designated facility or
29 nondesignated hospital shall not be liable for any of the following:
30 (1) An injury caused by an eloping or eloped person who has
31 been detained for a mental health disorder or addiction.
32 (2) An injury to, or the wrongful death of, an eloping or eloped
33 person who has been detained for a mental health disorder or
34 addiction.
35 (b) Nothing in this section shall exonerate a physician,
36 employee, or other staff person acting within the scope of his or
37 her official duties or employment for a designated facility or
38 nondesignated hospital from liability in either of the following
39 situations:

(1) If he or she acted or failed to act because of actual fraud, corruption, or actual malice.

(2) For injuries inflicted as a result of his or her own negligent or wrongful act or omission on an eloping or eloped person who has been detained for a mental health disorder or addiction under this part, in an effort to enforce the detention.

SEC. 10. Section 5150 of the Welfare and Institutions Code is amended to read:

5150. (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace ~~officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county~~ *officer or an authorized professional acting within the scope of his or her authorization* may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the ~~State Department of Health Care Services.~~ *department.* At a minimum, assessment, as defined in ~~Section 5150.4~~ *subdivision (c) of Section 5008*, and evaluation, as defined in subdivision ~~(a)~~ *(n)* of Section 5008, shall be conducted and provided on an ongoing basis. Crisis intervention, as defined in subdivision ~~(e)~~ *(g)* of Section 5008, may be provided concurrently with assessment, evaluation, or any other service. *The period of 72-hour detention for evaluation and treatment shall begin at the time that the person is initially detained pursuant to this section.*

(b) ~~The professional person in charge of a facility designated by the county~~ *(1) When an individual detained pursuant to subdivision (a) is taken to a designated facility* for evaluation and treatment, *the professional person in charge, a* member of the attending staff *of the designated facility*, or *an authorized* professional ~~person designated~~ *acting within the scope of his or her authorization* by the ~~county~~ *county,* shall assess the person to determine whether he or she can be properly served without being detained. *The assessment under this subdivision may be performed by an authorized professional in a designated ambulatory facility*

or any other setting in accordance with paragraph (2) of this subdivision and Section 5151. If in the judgment of the ~~professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county,~~ *authorized professional,* the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. ~~Nothing in this subdivision shall be interpreted to prevent a peace officer from delivering individuals to a designated facility for assessment under this section. Furthermore, the assessment requirement of this subdivision shall not be interpreted to require peace officers to perform any additional duties other than those specified in Sections 5150.1 and 5150.2.~~

(2) If the person detained for evaluation and treatment is taken to a designated ambulatory facility that is authorized by the county to conduct an assessment, the assessment shall be conducted by the professional person in charge of the designated ambulatory facility or his or her designee acting within the scope of his or her licensed profession. The assessment in a designated ambulatory facility may be performed by or in consultation with an authorized member of the professional staff of a designated inpatient facility using telehealth if the designated inpatient facility has agreed to admit the person in accordance with subdivision (a) upon a determination that an involuntary admission is appropriate.

(3) Nothing in this section shall be interpreted to prevent a peace officer, or an authorized professional employee of an emergency transport provider acting at the direction of the peace officer, from delivering individuals to a designated facility for an assessment under this section. Furthermore, the assessment requirement of this section shall not be interpreted to require peace officers or authorized professional employees of emergency transport providers acting at the direction of the peace officer to perform any additional duties other than those specified in Sections 5150.1 and 5150.2.

(4) If an individual detained under subdivision (a) is taken to an emergency department of a nondesignated hospital, as defined in subdivision (e) of Section 5150.10, the provisions of Article 1.1 (commencing with Section 5150.10) shall apply to the individual during his or her stay in the emergency department of a

1 *nondesignated hospital. This section does not require the peace*
2 *officer or authorized professional who detained the individual*
3 *pursuant to subdivision (a) to take or cause to take the individual*
4 *to an emergency department of a nondesignated hospital.*
5 *(5) The assessment may be performed, based on the clinical*
6 *condition and needs of a person detained for evaluation and*
7 *treatment, in either a designated inpatient facility, a designated*
8 *ambulatory facility, or any other setting. Nothing in this section*
9 *shall be construed to prevent an authorized member of the*
10 *professional staff of a designated inpatient facility from providing*
11 *consultation or other professional assistance by telehealth for a*
12 *person detained for evaluation and treatment in a designated*
13 *ambulatory facility or other setting.*
14 *(6) Notwithstanding paragraph (2) of subdivision (j) of Section*
15 *5008, or any regulation, if a person detained for evaluation and*
16 *treatment presents or is transferred to a designated ambulatory*
17 *facility, and the professional person in charge of the designated*
18 *ambulatory facility or his or her designee determines that the*
19 *person should be admitted to a designated inpatient facility for*
20 *further evaluation and treatment, the designated ambulatory facility*
21 *shall make good faith efforts to arrange placement for the person*
22 *in a designated inpatient facility. If the designated ambulatory*
23 *facility has been unable to arrange placement for the person in a*
24 *designated inpatient facility within 24 hours, the designated*
25 *ambulatory facility shall continue to provide evaluation and*
26 *treatment for the person beyond 24 hours in order to arrange for*
27 *placement and transfer of the person to a designated inpatient*
28 *facility, provided the designated ambulatory facility notifies the*
29 *county in which it is located and the mental health advocate for*
30 *the county that it is continuing to detain the person beyond 24*
31 *hours. The designated ambulatory facility shall not transfer or*
32 *send a person to an emergency department of a nondesignated*
33 *hospital except if the person requires examination or treatment*
34 *for a medical condition that is beyond the capability of the*
35 *designated ambulatory facility.*
36 (c) Whenever a person is evaluated by ~~a~~ *an authorized*
37 professional ~~person in charge of a facility designated by the county~~
38 ~~for evaluation or treatment, member of the attending staff, or~~
39 ~~professional person designated by the county~~ and is found to be
40 in need of mental health services, but is not admitted to the facility,

all available alternative services provided pursuant to subdivision (b) shall be offered as determined by the county mental health director.

(d) If, in the judgment of the *authorized* ~~professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or the professional person designated by the county,~~ *professional,* the person cannot be properly served without being detained, the admitting facility shall require an application in writing ~~stating the circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, and stating that the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county has probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false~~ *pursuant to Section 5150.3*.

(e) At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person. The person taking him or her into custody shall then furnish to the court a report generally describing the person's property so preserved and safeguarded and its disposition, in substantially the form set forth in Section 5211, except that if a responsible relative or the guardian or conservator of the person is in possession of the person's property, the report shall include only the name of the relative or guardian or conservator and the location of the property, whereupon responsibility of the person taking him or her into custody for that property shall terminate.

As used in this section, “responsible relative” includes the spouse, parent, adult child, domestic partner, grandparent, grandchild, or adult brother or sister of the person.

(f) (1) Each person, at the time he or she is first taken into custody under this section, shall be provided, by the person who takes him or her into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing. The information shall be in substantially the following form:

My name is ______________________________ .
I am a ______________________________ .
(peace officer/mental health professional)
with ______________________________ .
(name of agency)
You are not under criminal arrest, but I am taking you for an examination by mental health professionals at ______________________ .
____
(name of facility)
You will be told your rights by the mental health staff.

(2) If taken into custody at his or her own residence, the person shall also be provided the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

(g) The designated facility shall keep, for each patient evaluated, a record of the advisement given pursuant to subdivision (f) which shall include all of the following:

(1) The name of the person detained for evaluation.

(2) The name and position of the peace officer or mental health professional taking the person into custody.

(3) The date the advisement was completed.

(4) Whether the advisement was completed.

(5) The language or modality used to give the advisement.

(6) If the advisement was not completed, a statement of good cause, as defined by regulations of the State Department of Health Care Services.

(h) (1) Each person admitted to a facility designated by the county for evaluation and treatment shall be given the following information by admission staff of the facility. The information shall be given orally and in writing and in a language or modality accessible to the person. The written information shall be available to the person in English and in the language that is the person's primary means of communication. Accommodations for other disabilities that may affect communication shall also be provided. The information shall be in substantially the following form:

My name is ____ .
My position here is ____________________________________ .

You are being placed into this psychiatric facility because it is our professional opinion that, as a result of a mental health disorder, you are likely to (check applicable):

- □ Harm yourself.
- □ Harm someone else.
- □ Be unable to take care of your own food, clothing, and housing needs.

We believe this is true because

____

(list of the facts upon which the allegation of dangerous or gravely disabled due to mental health disorder is based, including pertinent facts arising from the admission interview).

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at ______________________________
(phone number for the county Patients' Rights Advocacy office) ______________________________ .

Your 72-hour period began ______________________________ .
(date/time)

(2) If the notice is given in a county where weekends and holidays are excluded from the 72-hour period, the patient shall be informed of this fact.

(i) For each patient admitted for evaluation and treatment, the facility shall keep with the patient's medical record a record of the advisement given pursuant to subdivision (h), which shall include all of the following:

(1) The name of the person performing the advisement.

(2) The date of the advisement.

(3) Whether the advisement was completed.

(4) The language or modality used to communicate the advisement.

(5) If the advisement was not completed, a statement of good cause.

SEC. 11. Section 5150.05 of the Welfare and Institutions Code is amended to read:

5150.05. (a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, ~~any~~ *a* person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.

(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by

the person subject to a determination described in subdivision (a) or anyone designated by that person.

(c) If the probable cause in subdivision (a) is based on the statement of a person other than ~~the~~ one authorized to take the person into custody pursuant to Section 5150, ~~a member of the attending staff, or a professional person,~~ the person making the statement shall be liable in a civil action for intentionally giving ~~any~~ *a* statement that he or she knows to be false.

(d) This section shall not be applied to limit the application of Section 5328.

SEC. 12. Section 5150.1 of the Welfare and Institutions Code is amended to read:

5150.1. ~~No~~ *(a) A* peace officer *or authorized professional employee of an emergency transport provider acting at the direction of a peace officer,* seeking to transport, or having transported, a person to a designated facility for assessment ~~under~~ *pursuant to* Section ~~5150,~~ *5151,* shall *not* be instructed by mental health personnel to take the person to, or keep the person at, a jail solely because of the unavailability of an acute ~~bed, nor shall the~~ *bed. The* peace officer *or the authorized professional employee of an emergency transport provider acting at the direction of the peace officer, shall not* be forbidden to transport the person directly to the designated facility. No mental health employee from any county, state, city, or any private agency providing ~~Short-Doyle~~ psychiatric emergency services shall interfere with a peace officer *or an authorized professional employee of an emergency transport provider acting at the direction of a peace officer* performing duties under Section 5150 by preventing the peace officer *from detaining a person for evaluation and treatment or preventing the peace officer or an authorized professional employee of an emergency transport provider acting at the direction of a peace officer* from entering a designated facility with the person ~~to be assessed, nor shall any~~ *for an assessment. An* employee of ~~such an agency~~ *a facility shall not* require the peace officer *or an authorized professional employee of an emergency transport provider acting at the direction of a peace officer* to remove the person without *an* assessment as a condition of allowing the peace officer *or an authorized professional employee of an emergency transport provider acting at the direction of a peace officer* to depart.

(b) An emergency transport provider, or any certified or licensed personnel of an emergency transport provider, shall not be civilly or criminally liable for any of the following that may be applicable to the transport of a person who has been detained for evaluation and treatment:

(1) The continuation of the detention for evaluation and treatment while transporting the person to a designated facility or an emergency department of a nondesignated hospital at the direction of a peace officer or authorized professional who detained the person for evaluation and treatment.

(2) The continuation of the detention for evaluation and treatment while transporting the person detained for evaluation and treatment to a designated facility or an emergency department of a nondesignated hospital at the direction of the treating emergency professional in an emergency department of a nondesignated hospital for an assessment or other service under Section 5151.

~~“Peace~~

(c) For purposes of this section, “peace officer” ~~for the purposes of this section also~~ means a *peace officer as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code and also includes a* jailer seeking to transport or transporting a person in custody to a designated facility for *an* assessment consistent with Section 4011.6 or 4011.8 of the Penal Code and Section 5150.

SEC. 13. Section 5150.2 of the Welfare and Institutions Code is amended to read:

5150.2. In each ~~county~~ *county,* whenever a peace officer *or the authorized professional employee of an emergency transport provider acting at the direction of the peace officer* has transported a person to a designated facility for *an* assessment ~~under Section 5150, that~~*, the* officer *or professional employee of an emergency transporter* shall be detained no longer than the time necessary to complete documentation of the factual basis of the detention ~~under Section 5150 and a safe~~ *for evaluation and treatment and effectuate a prompt, safe,* and orderly transfer of physical custody of the person. ~~The documentation shall include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual~~

~~required psychiatric evaluation under the standards of Section 5105.~~

~~Each county shall establish disposition procedures and guidelines with local law enforcement agencies as necessary to relate to persons not admitted for evaluation and treatment and who decline alternative mental health services and to relate to the safe and orderly transfer of physical custody of persons under Section 5150, including those who have a criminal detention pending.~~

SEC. 14. Section 5150.3 is added to the Welfare and Institutions Code, to read:

5150.3. (a) (1) The peace officer, or an authorized professional acting within the scope of his or her authorization by the county, shall complete and sign an application for detention for evaluation and treatment, in the form prescribed by subdivision (g), stating the circumstances under which the person's condition was called to the attention of the peace officer or authorized professional, and stating that the peace officer or authorized professional has probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself or herself, or gravely disabled.

(2) The documentation shall include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer or authorized professional to believe that the person should be detained for evaluation and treatment in accordance with Section 5150. If the probable cause is based on the statement of a person other than the peace officer or authorized professional, the person shall be liable in a civil action for intentionally giving a statement that he or she knows is false.

(3) A designated facility or nondesignated hospital shall require presentation of the application as a condition of continuation of the detention for evaluation and treatment. If the application is not presented to the designated facility or nondesignated hospital, as applicable, the person shall be immediately released from detention for evaluation and treatment.

(4) An application for detention for evaluation and treatment shall be valid in all counties to which the person may be taken to a designated facility.

(b) (1) If the person detained by a peace officer or authorized professional is in a location other than a designated facility or

nondesignated hospital, the original or copy of the application for detention for evaluation and treatment shall be presented to the designated facility under paragraph (2) or the nondesignated hospital under paragraph (3).

(2) If after detention under Section 5150, the person is first taken to a designated facility, the original or a copy of the signed application for detention for evaluation and treatment shall be presented to the designated facility.

(3) If after detention under Section 5150, the person is first taken to a nondesignated hospital, the original or a copy of the signed application for detention for evaluation and treatment shall be presented to the nondesignated hospital. If the person is subsequently transferred to a designated facility, the nondesignated hospital shall deliver the original or a copy of the signed application for detention for evaluation and treatment to the designated facility. If the person is discharged from the nondesignated hospital under Section 5150.15 or 5150.16, without a transfer to a designated facility, the nondesignated hospital shall maintain the original or a copy of the original signed application for detention for evaluation and treatment.

(c) If a person detained for evaluation and treatment is subsequently released from detention for evaluation and treatment pursuant to Section 5150.15 or 5151, the application for detention for evaluation and treatment in the possession of a designated facility or nondesignated hospital shall be retained for the period of time required by the medical records retention policy of the designated facility or nondesignated hospital.

(d) The determination of a peace officer or authorized professional to detain a person under Section 5150 and complete and sign an application for detention for evaluation and treatment, shall be based solely on whether the person meets the criteria for detention for evaluation and treatment as set forth in Sections 5150 and 5150.05. The determination shall not be delayed, denied, or refused based on the availability of beds or services at designated facilities to which a person may be taken under this article.

(e) If a person detained for evaluation and treatment under Section 5150 is transported by a professional employee of an emergency transport provider to a designated facility or nondesignated hospital at the request of a peace officer or an authorized professional, the peace officer or authorized professional

shall give the application for detention for evaluation and treatment to the professional employee of the emergency transport provider if the peace officer or authorized professional does not accompany the person to the designated facility or nondesignated hospital.

(f) A copy of the application for detention for evaluation and treatment shall be given to an emergency transport provider if the person detained for evaluation and treatment is transported from a nondesignated hospital to a designated facility or from a designated facility to another designated facility.

(g) Not later than July 1, 2016, the department shall adopt and make available a standardized form of the application for detention for evaluation and treatment that shall be used by peace officers and authorized professionals to apply for detention of a person for evaluation and treatment under Section 5150 and by authorized professionals to release a person from detention for evaluation and treatment pursuant to Section 5150.15 or 5151. In developing the form, the department shall request comments from stakeholders including the organizations described in subdivision (b) of Section 5400. The form of the application for detention for evaluation and treatment shall, at a minimum, provide all of the following:

(1) A description of the person's behavior and other relevant facts that provide the basis for probable cause under Sections 5150 and 5150.05 of the person's detainment for evaluation and treatment.

(2) For persons detained for evaluation and treatment who are first taken to an emergency department of a nondesignated hospital, documentation of the facts and conclusions that provide the basis for the determination of medical clearance, excluding a psychiatric emergency medical condition, by the emergency professional treating the person in the emergency department to transfer the person to a designated facility.

(3) Documentation of the facts and conclusions that provide the basis for the determination by an authorized professional authorized to perform an assessment that the person should be admitted for involuntary evaluation and treatment under Section 5152.

(4) Determination of the facts and conclusions that support the determination by an authorized professional authorized to release a person from detention in accordance with Section 5150.14 or 5151.

(5) Request by a peace officer under Section 5152.1 for notification of the person's release or discharge by a designated facility or nondesignated hospital.

SEC. 15. Section 5150.4 of the Welfare and Institutions Code is repealed.

~~5150.4. "Assessment" for the purposes of this article, means the determination of whether a person shall be evaluated and treated pursuant to Section 5150.~~

SEC. 16. Article 1.1 (commencing with Section 5150.10) is added to Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, to read:

Article 1.1. Persons Detained in Nondesignated Hospitals

5150.10. Unless the context otherwise requires, the following definitions shall govern the construction of this article:

(a) "Emergency department of a nondesignated hospital" means a basic, comprehensive, or standby emergency medical service that is approved by the State Department of Public Health as a special or supplemental service of a nondesignated hospital. For purposes of this part, an emergency department of a nondesignated hospital shall include an observation or similar unit of the hospital that meets both of the following criteria:

(1) The unit is operated under the direction and policies of the emergency department.

(2) The unit provides continuing emergency services and care to patients prior to an inpatient admission, transfer, or discharge.

(b) "Emergency professional" means either of the following:

(1) A physician and surgeon who is board certified or pursuing board certification in emergency medicine, or a qualified licensed person, as defined in subdivision (g), during any scheduled period that he or she is on duty to provide medical screening and treatment of patients in an emergency department of a nondesignated hospital.

(2) A physician and surgeon, or a qualified licensed person, as defined in subdivision (g), during any scheduled period that he or she is on duty to provide medical screening and treatment of patients in the emergency department of a nondesignated hospital that is a critical access hospital within the meaning of Section 1250.7 of the Health and Safety Code. A physician and surgeon on duty under this paragraph shall include a physician and surgeon

on call for a standby emergency medical service who is responsible to provide professional coverage for the emergency department. A physician and surgeon on duty under this paragraph does not include a physician and surgeon who is providing on-call specialty coverage services to the emergency department of a nondesignated hospital, unless the physician and surgeon is an emergency professional under paragraph (1).

(c) "Emergency services and care" has the same meaning as in subdivision (a) of Section 1317.1 of the Health and Safety Code.

(d) "EMTALA" means the Emergency Medical Treatment and Labor Act, and regulations adopted pursuant thereto, as defined in Section 1395dd of Title 42 of the United States Code.

(e) "Nondesignated hospital" means a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code, that is not a designated facility.

(f) "Psychiatric emergency medical condition" has the same meaning in subdivision (k) of Section 1317.1 of the Health and Safety Code.

(g) "Qualified licensed person" means a licensed person designated by the medical staff and governing body of a nondesignated hospital to provide emergency services and care, to the extent permitted by applicable law, in an emergency department of the nondesignated hospital under the supervision of a physician and surgeon.

(h) "Stabilized" has the same meaning as in subdivision (j) of Section 1317.1 of the Health and Safety Code.

5150.11. (a) The Legislature finds and declares all of the following:

(1) A person who has been detained for evaluation and treatment pursuant to Section 5150 should be taken to a designated facility rather than an emergency department of a nondesignated hospital.

(2) A person who has been detained for evaluation and treatment pursuant to Section 5150 should be detained in an emergency department of a nondesignated hospital only for the time necessary to provide required emergency services and care and obtain medical clearance, unless the person requires an admission for inpatient services.

1 (3) A person who has been detained for evaluation and treatment
2 pursuant to Section 5150 has the right to receive a prompt
3 assessment to determine the appropriateness of the detention and
4 the need for evaluation and treatment at a designated facility.
5 (b) It is also the intent of the Legislature that nothing in this
6 chapter shall be construed to require a peace officer or any other
7 authorized professional to take a person detained for evaluation
8 and treatment to an emergency department of a nondesignated
9 hospital instead of taking the person to a designated facility, unless
10 the peace officer or authorized professional reasonably determines
11 that the person is in need of emergency care and services that
12 should be provided at an emergency department of a nondesignated
13 hospital before the person is transported to a designated facility.
14 5150.12. (a) This section shall apply to a person who has been
15 detained for evaluation and treatment by a peace officer or an
16 authorized professional and is taken to an emergency department
17 of a nondesignated hospital for emergency services and care.
18 (b) While the person is in the emergency department of the
19 nondesignated hospital, the detention of the person for evaluation
20 and treatment shall continue, unless the person is released from
21 detention pursuant to Section 5150.15 or 5150.16.
22 5150.13. (a) This section shall apply if, during a person's
23 examination or treatment in an emergency department, there is a
24 need for a probable cause determination that the person should be
25 detained for evaluation and treatment.
26 (b) If a person who has not been detained for evaluation and
27 treatment has signs or symptoms, in the judgment of the treating
28 emergency professional, that indicate probable cause for detention
29 for evaluation and treatment, the person shall have the right to a
30 prompt probable cause determination in accordance with any of
31 the following:
32 (1) The hospital may contact the county to arrange for a probable
33 cause determination by an authorized professional, including, but
34 not limited to, a member of a mobile crisis team.
35 (2) (A) If the county in which the nondesignated hospital is
36 located has a local or regional liaison, the hospital may contact the
37 local or regional liaison to arrange for an authorized professional
38 to provide a prompt probable cause determination of the person.
39 (B) The local or regional liaison shall advise the nondesignated
40 hospital within 30 minutes of the time of the initial contact whether

an authorized professional can perform the probable cause determination within two hours from the time of the initial contact with the local or regional liaison.

(C) The probable cause determination shall be based solely on the criteria for detaining a person for evaluation and treatment. The probable cause determination shall not consider the availability of beds or services at designated facilities within or outside of the county.

(D) The probable cause determination may be conducted by an authorized professional utilizing telehealth.

(3) The treating emergency professional may conduct a probable cause determination and, upon a finding of probable cause, detain the person for evaluation and treatment in accordance with Sections 5150 and 5150.3.

(c) If the person is detained for evaluation and treatment pursuant to this section, the detention shall continue during his or her stay in the emergency department of a nondesignated hospital, unless the person is released from detention pursuant to Section 5150.15.

5150.14. (a) This section shall apply to a person who is detained pursuant to Section 5150 for evaluation and treatment in a nondesignated hospital emergency department or has been detained pursuant to Section 5150 for evaluation and treatment by a peace officer and taken to an emergency department of a nondesignated hospital.

(b) (1) Except as provided in subdivision (e), the nondesignated hospital shall notify the county in which the nondesignated hospital is located of the person's detention status.

(2) If the person was detained for evaluation and treatment and taken to the emergency department of the nondesignated hospital pursuant to Section 5150.12, the notification shall occur after the hospital has performed an initial medical screening of the person in accordance with paragraphs (1) and (2) of subdivision (a) of Section 1317.1 of the Health and Safety Code.

(3) If the person is first detained for evaluation and treatment in the emergency department of the nondesignated hospital pursuant to Section 5150.13, the notification shall occur when the probable cause determination has been completed.

(c) The notification to the county shall be made using the 24-hour toll-free telephone number established by the county's

1 mental health program for psychiatric emergency services and
2 crisis stabilization if the county's mental health program has a
3 24-hour toll-free telephone number in operation on January 1,
4 2016, for this purpose. The notification shall be documented in
5 the patient's medical record.
6 (d) The nondesignated hospital shall advise the county of all of
7 the following:
8 (1) The time when the 72-hour detention period for evaluation
9 and treatment expires.
10 (2) An estimate of the time when the person will be medically
11 stable for transfer to a designated facility.
12 (3) The county in which the person resides, if known.
13 (e) The notification to the county under this section shall not
14 be required if the treating emergency professional determines that
15 the person will be admitted, pursuant to Section 5150.16, to an
16 acute care bed of a nondesignated hospital for the primary purpose
17 of receiving acute inpatient services for a medical condition that
18 is in addition to the person's psychiatric condition.
19 5150.15. (a) This section shall establish a process for releasing
20 a person from detention for evaluation and treatment during the
21 period of time that the person is receiving emergency services and
22 care in the emergency department of a nondesignated hospital.
23 (b) If the treating emergency professional determines that there
24 is no longer probable cause to continue the detention for evaluation
25 and treatment, the treating emergency professional may initiate a
26 followup probable cause determination to determine whether the
27 person may be released from detention for evaluation and
28 treatment. The followup probable cause determination shall be
29 made in accordance with either of the following:
30 (1) The hospital may contact the county, or a local or regional
31 liaison if authorized by the county, to arrange for an authorized
32 professional to perform a followup probable cause determination
33 to determine whether the person may be released from detention
34 for evaluation and treatment. If a county or a local or regional
35 liaison cannot arrange for an authorized professional to make the
36 determination within two hours of the initial call to the county or
37 the local or regional liaison, the treating emergency professional
38 may perform a followup probable cause determination to determine
39 whether the person may be released from detention for evaluation
40 and treatment.

1 (2) The treating emergency professional, without first contacting
2 the county or a local or regional liaison, may perform a followup
3 probable cause determination to determine whether the person
4 may be released from detention for evaluation and treatment.
5 (c) The determination under this section to release a person from
6 detention for evaluation and treatment shall be based on whether
7 there is probable cause to continue the detention for evaluation
8 and treatment. The determination to continue or release the person
9 from detention shall not be based on the availability of beds or
10 services at designated facilities within or outside of the county.
11 (d) The followup probable cause determination under this section
12 may be conducted by an authorized professional utilizing
13 telehealth.
14 5150.16. (a) This section shall apply to a person detained for
15 evaluation and treatment who is admitted to a general acute care
16 hospital bed for acute medical services. This section shall apply
17 to all general acute care hospitals, including general acute care
18 hospitals that are designated facilities.
19 (b) If the person detained for evaluation and treatment is
20 admitted to a general acute care hospital bed for the primary
21 purpose of receiving acute inpatient services for a medical
22 condition that is in addition to the person's psychiatric condition,
23 the effect on the detention for evaluation and treatment while
24 receiving acute medical services shall be as follows:
25 (1) If the hospital offers to provide assessment, evaluation, and
26 crisis intervention services and the person consents to the services
27 on a voluntary basis in addition to acute medical services, the
28 detention for evaluation and treatment shall be released.
29 (2) If the hospital offers to provide assessment, evaluation, and
30 crisis intervention services and the person refuses to consent to
31 the services on a voluntary basis in addition to acute medical
32 services, the detention for evaluation and treatment shall continue
33 in effect during the acute hospital stay.
34 (3) If the hospital does not have the capability to provide
35 assessment, evaluation, and crisis intervention services, the
36 detention for evaluation and treatment shall be released.
37 (c) The release of the person from detention for evaluation and
38 treatment shall be communicated to the person and documented
39 in the person's medical record.

1 (d) This section shall not apply to a person detained for
2 evaluation and treatment who meets both of the following:
3 (1) The person does not require acute inpatient services for a
4 medical condition.
5 (2) The person is awaiting a transfer to a designated facility and
6 is placed in an acute bed of the nondesignated hospital for the
7 purpose of securing the protection of the person or other persons,
8 or both, in the nondesignated hospital pending the transfer of the
9 person to a designated facility.
10 (e) In all cases described in subdivision (b), if the discharge
11 plan for the patient provides for followup evaluation and treatment
12 at a psychiatric facility, the patient shall be advised of the
13 recommended need for the followup evaluation and treatment.
14 (f) If the person is not able or willing to accept treatment on a
15 voluntary basis, or to accept the referral or transfer to a psychiatric
16 facility, the hospital shall obtain a new probable cause
17 determination for detention for evaluation and treatment pursuant
18 to Section 5150 in order to take or cause the person to be taken to
19 a designated facility. Upon request by the hospital, a county shall
20 arrange for an authorized professional to conduct a probable cause
21 determination in a timely manner, which may be performed by the
22 authorized professional utilizing telehealth.
23 5150.17. (a) This section, together with Sections 5150.18 and
24 5150.19, shall apply to the placement with a designated facility of
25 a person in a nondesignated hospital emergency department who
26 has been detained for evaluation and treatment.
27 (b) The person may be placed with any designated facility that
28 has the capability to meet the needs of the person, including a
29 designated ambulatory facility.
30 (c) If placement is made with a designated ambulatory facility,
31 personnel at the designated ambulatory facility shall confirm
32 whether the facility can meet the needs of the person within the
33 scope of its designation and capability.
34 5150.18. (a) This section shall apply to the placement with a
35 designated facility for a person described in Section 5150.17 if the
36 person has a psychiatric emergency medical condition.
37 (b) If a person, in the judgment of the treating emergency
38 professional, has a psychiatric emergency medical condition, the
39 placement with a designated facility shall be made as follows:

(1) The placement may be with any designated facility that has the capability and capacity to provide evaluation and treatment for the person, whether that designated facility is located within or outside of the county of the hospital.

(2) The treating emergency professional shall determine the mode of transportation, including personnel and equipment, that are appropriate for the transport of the person to the designated facility.

(3) In the event of a disagreement as to whether the person under this section has a psychiatric emergency medical condition, the judgment of the treating emergency professional shall prevail.

(4) The placement of a person described in this subdivision shall take precedence over provider networks.

(c) If the person, in the judgment of the treating emergency professional, does not have a psychiatric emergency medical condition, the placement of the person with a designated facility for evaluation and treatment shall be deemed to be made for a medical reason within the meaning of Section 1317.2 of the Health and Safety Code.

(d) This section shall also apply to a person who is medically clear, but is being held in an inpatient unit of the nondesignated hospital for the purposes of ensuring the safety and security of the person or other persons, pending placement of the person with a designated facility for evaluation and treatment.

5150.19. (a) This section describes assistance that may be available to an emergency department of a nondesignated hospital for the placement with a designated facility of a person described in Section 5150.17.

(b) If a person has been taken to or detained by a county-authorized professional in the emergency department of the nondesignated hospital, the authorized professional shall assist the nondesignated hospital in arranging for the placement of the person with an appropriate designated facility.

(c) If a person is detained for evaluation and treatment by a peace officer or a treating emergency professional in the emergency department of the nondesignated hospital, the hospital may contact the local or regional liaison, if authorized for the county in which the nondesignated hospital is located, to assist the hospital in arranging for the placement of the person with a designated facility, as follows:

(1) Contact with the local or regional liaison may be initiated when the treating emergency professional has determined that the person is medically clear for placement with a designated facility.

(2) The hospital shall inform the local and regional liaison whether the person has a psychiatric emergency medical condition that requires a transport of the person in accordance with the EMTALA obligations for making an appropriate transfer.

(d) A nondesignated hospital may pursue efforts to obtain placement of the person without first contacting the local or regional liaison under this section or in addition to requesting assistance that may be provided by the local or regional liaison.

5150.20. (a) The determination of probable cause to detain a person for evaluation and treatment shall be independent of a determination as to whether the person has a psychiatric emergency medical condition for the provision of emergency services and care.

(b) A determination of probable cause to detain a person for evaluation and treatment, whether by a peace officer or an authorized professional, shall not be deemed to constitute a psychiatric emergency medical condition unless a treating emergency professional has determined that the person has a psychiatric emergency medical condition.

(c) A determination by a treating emergency professional that a person has a psychiatric emergency medical condition shall not be deemed to constitute probable cause under Section 5150 that the person may be detained for evaluation and treatment.

(d) A determination by a treating emergency professional that a person detained for evaluation and treatment does not have a psychiatric emergency medical condition, or that the person's psychiatric emergency medical condition is stabilized, shall not be deemed to constitute a release of the person from detention for evaluation and treatment.

5150.21. (a) A nondesignated hospital and the professional staff of the nondesignated hospital shall not be civilly or criminally liable for transferring a person detained for evaluation and treatment to a designated facility in accordance with this article.

(b) The peace officer or authorized professional responsible for the detention of the person for evaluation and treatment who transfers the custody of the person to an emergency professional

of a nondesignated hospital, shall not be civilly or criminally liable for any of the following:

(1) The continuation and enforcement of the detention for evaluation and treatment during the person's stay in the emergency department of the nondesignated hospital prior to the discharge of the person in accordance with this article.

(2) The release of the person from detention for evaluation and treatment in accordance with this article.

(3) The transfer of the person detained for evaluation and treatment to a designated facility in accordance with this article.

SEC. 17. Article 1.2 (commencing with Section 5150.30) is added to Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, to read:

Article 1.2. Voluntary Patients

5150.30. (a) A provider of ambulance services licensed by the Department of the California Highway Patrol or operated by a public safety agency, and the employees of those providers who are certified or licensed under Section 1797.56 of the Health and Safety Code, shall be authorized to transport a person who is transferring on a voluntary basis to a designated facility for psychiatric treatment. This section shall apply to transfers from any type of facility, including nondesignated hospitals and other facilities.

(b) A person shall not be detained for evaluation and treatment solely for the purpose of transporting the person, or transferring the person by a provider of ambulance services, to a designated facility or an emergency department of a nondesignated hospital.

(c) Not later than July 1, 2016, the department shall adopt and make available a standardized form that will enable voluntary patients to consent to transfer between facilities by a provider of ambulance services. The form shall be provided to voluntary patients to sign before the arrival of the provider of ambulance services. The form shall be kept in the patient's chart. Copies of the form shall be given to the patient and the provider of ambulance services.

(d) This section shall apply to all patients who are on voluntary status, regardless of whether the person was previously detained for evaluation and treatment at any point during the course of

treatment at a nondesignated hospital or designated facility prior to the transfer.

(e) No person shall require a person to be subject to detention for evaluation and treatment for the purpose of authorizing or providing evaluation, treatment, or admission to a facility, or as a condition for providing or paying for medical services, care, or treatment, including emergency services and care, unless there is probable cause under Section 5150 to detain the person for evaluation and treatment and the person cannot be properly served on a voluntary basis. Nothing in this part shall be construed as preventing a person subject to detention for evaluation and treatment from receiving evaluation or treatment on a voluntary basis unless there has been an adjudication under this part that the person lacks the capacity to do so.

SEC. 18. The heading of Article 1.3 (commencing with Section 5151) is added to Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, to read:

Article 1.3. Admission to a Designated Facility

SEC. 19. Section 5151 of the Welfare and Institutions Code is amended to read:

5151. *(a)* If ~~the~~ *a designated* facility ~~designated by the county~~ for evaluation and treatment admits the person, it may detain him or her for evaluation and treatment for a period not to exceed 72 ~~hours. Saturdays, Sundays, and holidays may be excluded from the period if the State Department of Health Care Services certifies for each facility that evaluation and treatment services cannot reasonably be made available on those days. The certification by the department is subject to renewal every two years. The department shall adopt regulations defining criteria for determining whether a facility can reasonably be expected to make evaluation and treatment services available on Saturdays, Sundays, and holidays.~~ *hours from the time that the person was initially detained pursuant to subdivision (a) of Section 5150.*

~~Prior~~

(b) Prior to admitting a person to the facility for treatment and ~~evaluation pursuant to Section 5150~~ *evaluation*, the professional person in charge of the facility or his or her designee shall ~~assess~~

conduct an assessment of the individual in person to determine the appropriateness of the involuntary detention.

SEC. 20. Section 5151.1 is added to the Welfare and Institutions Code, to read:

5151.1. If the assessment results in a determination that the person is in need of mental health services, but he or she is not admitted to the facility, the designated facility shall provide the person with appropriate referrals and a list of alternative services and other resources that are appropriate to the needs of the person. The alternative services and other resources shall include both of the following, as applicable:

(a) The services described in subdivision (b) of Section 5150.

(b) The services for persons with severe mental illness and substance use disorders posted by a county on its Internet Web site pursuant to Section 5013.

SEC. 21. Section 5151.2 is added to the Welfare and Institutions Code, to read:

5151.2. (a) Each county shall establish disposition procedures and guidelines with local law enforcement agencies for the safe and orderly transfer of persons detained for evaluation and treatment by a peace officer, who has requested notification under Section 5152.1 of the person's release from detention for evaluation and treatment in accordance with Section 5150.15, 5150.16, or 5151. The disposition procedures and guidelines shall include persons who are not admitted for evaluation and treatment and who decline alternative mental health services and persons who have a criminal detention pending.

(b) The disposition procedures and guidelines should include interagency communication between law enforcement agencies located within the county, as well as law enforcement agencies located in other counties, that take or arrange to take persons detained for evaluation and treatment under Section 5150 to health facilities within the county. The disposition procedures and guidelines, including updates, shall be disseminated to designated facilities and nondesignated hospitals.

SEC. 22. Section 5152.1 of the Welfare and Institutions Code is amended to read:

~~5152.1. The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's~~

~~designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the following conditions apply:~~

5152.1. (a) A designated facility or nondesignated hospital shall notify the county mental health director, or the director's designee, and the law enforcement agency that employs the peace officer who makes the application for detention for 72-hour evaluation and treatment pursuant to Section 5150, if the person admitted pursuant to Section 5152 will be discharged after a 72-hour inpatient admission, when the person is not admitted by the designated facility, when the person discharged before the expiration of the 72-hour inpatient admission, when the person discharged from detention for evaluation and treatment is released under Section 5150.15, 5150.16, or 5151, or if the person elopes from a designated facility or nondesignated hospital, if both of the following conditions apply:

~~(a)~~

(1) The peace officer *who made the application for detention for evaluation and treatment* requests ~~such~~ notification *of the person's release or discharge* at the time he or she makes the application *for detention for evaluation and treatment* and the peace officer ~~certifies~~ *certified* at that time in writing that the person has been ~~referred to the facility~~ *detained for evaluation and treatment* under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint. *The application for detention for evaluation and treatment shall include one or more methods of contacting a person at the law enforcement agency who may receive the notification.*

~~(b)~~

(2) The notice is limited to the person's name, address, date of admission ~~for 72-hour evaluation and treatment~~ *or initial service,* and date of release.

~~If~~

(b) If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information

obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after receipt of notification.

(c) The notice required by this section shall be made prior to the release or discharge of the person, if possible. The designated facility or nondesignated hospital shall consider the distance of the law enforcement agency to the location of the designated facility or nondesignated hospital in giving the notice. The peace officer or other representative of the law enforcement agency receiving the notice shall promptly advise the designated facility or nondesignated hospital whether the peace officer or other law enforcement agency representative shall take custody of the person upon his or her release or discharge from the designated facility or nondesignated hospital and, if so, the time at which the peace officer or other law enforcement agency representative will be present at the designated facility or nondesignated hospital.

(d) Nothing in this section shall be construed to require the designated facility or nondesignated hospital to delay the discharge of a person for purposes of awaiting the arrival of the peace officer or another representative of the law enforcement agency.

SEC. 23. Section 5152.2 of the Welfare and Institutions Code is repealed.

~~5152.2. Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officers pursuant to Section 5152.1.~~

SEC. 24. Section 5152.2 is added to the Welfare and Institutions Code, to read:

5152.2. In addition to the request for notification set forth in the application for detention for evaluation and treatment, each law enforcement agency shall arrange with the county mental health director for a method for designated facilities and nondesignated hospitals to give prompt notification to peace officers under Section 5152.1. The methods for notification for each county shall be disseminated by the county to the designated facilities and nondesignated hospitals located within the county.

SEC. 25. Section 5153 of the Welfare and Institutions Code is amended to read:

5153. Whenever possible, officers charged with apprehension of persons pursuant to this ~~article~~ *chapter* shall dress in plain clothes and travel in unmarked vehicles.

SEC. 26. Section 5270.50 of the Welfare and Institutions Code is amended to read:

5270.50. *(a)* Notwithstanding Section 5113, if the provisions of Section 5270.35 have been met, the professional person in charge of the facility providing intensive treatment, his or her designee~~, and the professional person~~ *the medical director of the facility or his or her designee described in Section 5270.53, the psychiatrist* directly responsible for the person's treatment*, or the psychologist* shall not be held civilly or criminally liable for any action by a person released before~~ or at~~ the end of 30 days pursuant to this article.

(b) The professional person in charge of the facility providing intensive treatment or his or her designee, the medical director of the facility or his or her designee described in Section 5270.35, the psychiatrist directly responsible for the person's treatment, or the psychologist shall not be held civilly or criminally liable for any action by a person released at the end of the 30 days pursuant to this article.

(c) The attorney or advocate representing the person, the court-appointed commissioner or referee, the certification review hearing officer conducting the certification review hearing, and the peace officer responsible for detaining the person shall not be civilly or criminally liable for any action by a person released at or before the end of 30 days pursuant to this article.

O

Lanterman-Petris-Short Modernization Act
AB 1300 (Ridley-Thomas)
Fact Sheet

Background

Established in 1967, the Lanterman-Petris-Short Act (LPS Act) governs the involuntary commitment of individuals for psychiatric treatment in California. In the 48 years since its passage, there have been significant changes in the mental health delivery system, adversely impacting a patient's ability to obtain prompt evaluation and treatment as required by current law. In addion, the fragmented and inconsistent application of the LPS Act by California's 58 counties has led to an increasing and often inappropriate dependence on hospital emergency departments to care for this population, without the necessary resources. This has resulted in individuals with mental illness languishing for hours, days and sometimes weeks, awaiting psychiatric assessment and treatment.

Bill Purpose

The purpose of this bill is to modernize sections 5150, 5151 and 5152 of the Welfare and Institutions Code or LPS Act. The LPS Act currently lacks guidance for non-LPS designated facilities involved in an involuntary hold, resulting in wide variations in the application of the law from county to county, from city to city and even from hospital to hospital. This bill makes clarifying changes to better define the various steps of a 5150 detention process to ensure consistent statewide application and to ensure that patients receive the most appropriate care in the least restrictive environment appropriate to their needs.

Bill Summary

In summary, the primary objectives of this bill are to:

- Clearly articulate when a 5150 hold starts, stops, is discontinued, and who may perform these decision-making functions;
- Increase the emphasis on the prompt provision of services in both LPS-designated and non-LPS designated facilities;
- Clarify a patient's involuntary 5150 hold status when receiving involuntary psychiatric treatment out of their county of residence, across county lines and when, admitted into a medical floor of a hospital;
- Incorporate the use of tele-health for involuntary treatment, assessment and evaluation purposes; and,
- Create optional county mental health "local or regional liaisons" to facilitate increased communication between hospitals and community services.

Co-Sponsors

California Hospital Association
California Chapter of the American College of Emergency Physicians

Opposition

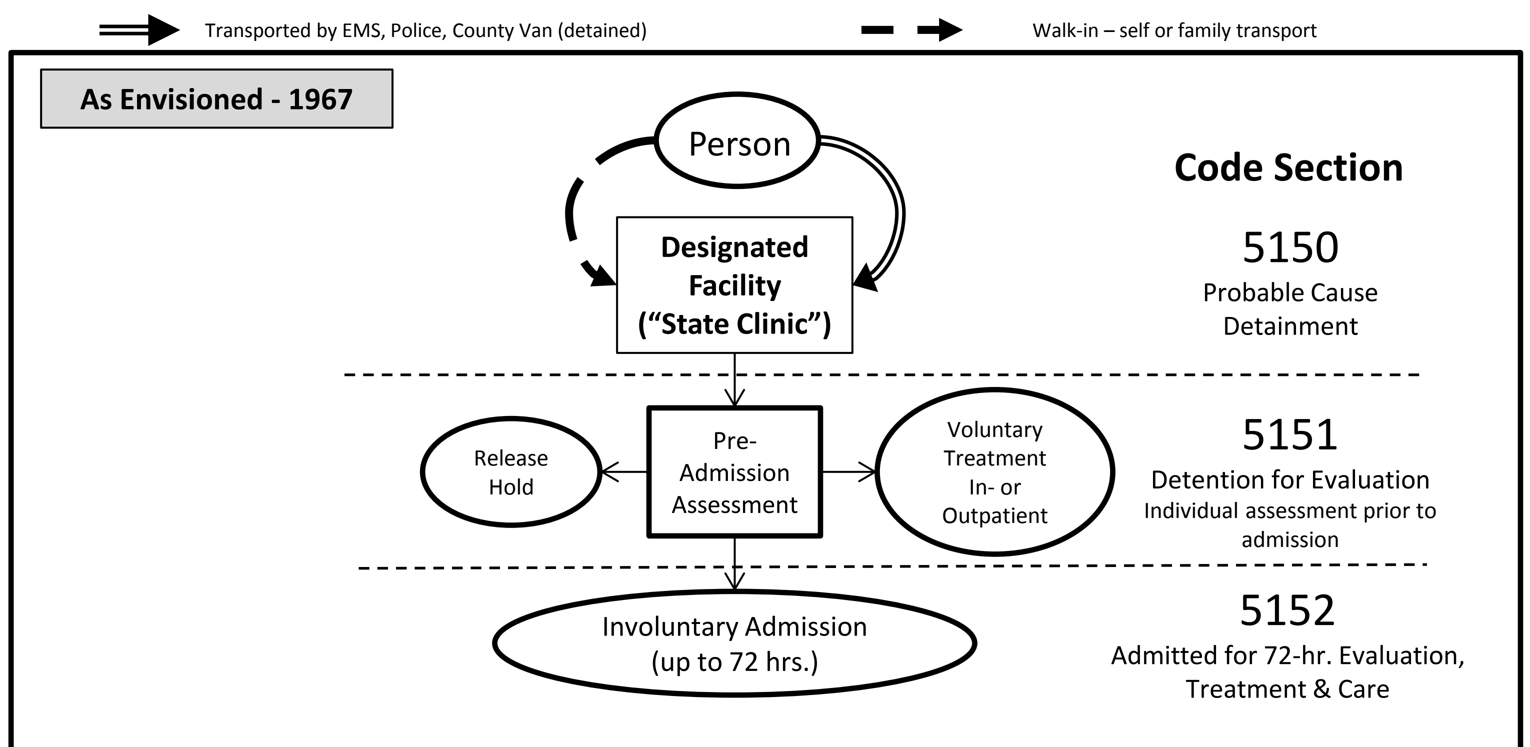
None

1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org

Welfare & Institutions Code – Involuntary Treatment (Chapter 2)
Article 1 – Detention of Mentally Disordered Persons for Evaluation & Treatment

Transported by EMS, Police, County Van (detained)

Walk-in – self or family transport



Current Process - 2015

Person

Non-Designated Hospital Emergency Department

EMTALA* Requirements
- Emergency Services
- Psych. Screening
- Medical Clearance

Designated Hospital Emergency Department

Crisis Stabilization Unit (or equivalent)

Designated Hospital / Psychiatric Health Facility

Welfare & Institutions Code 1799.111 24-hr. Hold

Probable Cause Assessment for Hold (by county team or authorized professional)

Hold (or hold for transfer**)

Code Section

5150

Release Hold

Pre-Admission Assessment

Voluntary Treatment

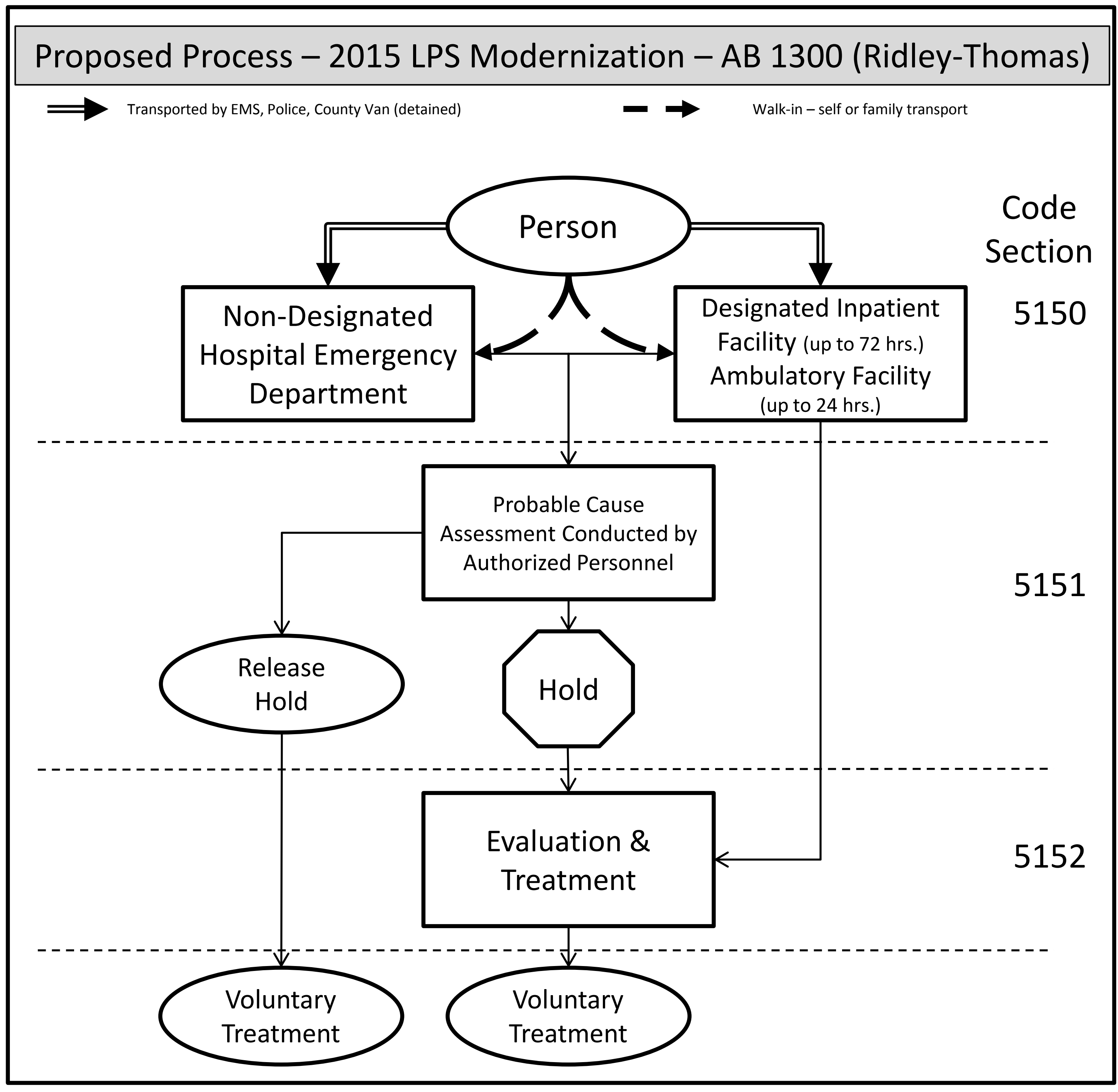
5151

Involuntary Admission (up to 72 hrs.)

Voluntary Treatment

5152

* Emergency Medical Treatment and Active Labor Act
** Some counties require authorization before a hold for transfer.


Proposed Process – 2015 LPS Modernization – AB 1300 (Ridley-Thomas)
Transported by EMS, Police, County Van (detained)
Walk-in – self or family transport
Person
Code Section
Non-Designated Hospital Emergency Department
Designated Inpatient Facility (up to 72 hrs.) Ambulatory Facility (up to 24 hrs.)
5150
Probable Cause Assessment Conducted by Authorized Personnel
5151
Release Hold
Hold
Evaluation & Treatment
5152
Voluntary Treatment
Voluntary Treatment

SBAR Safe Pain Medication Prescribing in ED

SITUATION:
Safe Pain Medicine Prescribing in Emergency Departments (ED) has been successfully implemented in San Diego and Imperial Counties. Low satisfaction scores from patients treated in the ED is being partially attributed to the implementation of safe pain medicine prescribing guidelines. It has been recently reported, through anecdote, that low satisfaction scores from ED survey data has been a source of tension and stress between prescribing physicians and experience professionals and administrators.

Financial incentives/penalties associated with the survey results without context and understanding can limit improvement.

BACKGROUND:
In September 2013, Safe Pain Medicine Prescribing in Emergency Departments was launched in San Diego and Imperial Counties by the San Diego and Imperial County Prescription Drug Abuse Medical Task Force.

Specific guidelines have been created to provide pain relief treatment that strives to avoid mistakes or abuse of pain medicine that can cause serious health problems or death.

Reported in the October 2014 update (www.sandiegosafeprescribing.org); "The San Diego Safe Prescribing Project for the ED has received the National Association of Counties Award. California ACEP, the California Medical Association and the California Hospital Association have adopted the guidelines. Los Angeles County has adopted the program for their 77 EDs. Other counties around California are following. "

ASSESSMENT:
ED experience feedback has not been a component of evaluating the effectiveness of the safe pain medication prescribing initiative. There are anecdotes that negative patient experience may result, related to denied opiate prescription. This raises concerns about the tension between patient experience feedback and implementation of safe prescribing practices.

Concern is being expressed by clinicians that there is a perception that patient satisfaction is becoming more important than safety in prescribing, although there has not been a systematic survey to determine the validity or extent of concern.

Patient experience survey is an important measurement tool, and should be used to achieve both high survey scores and safe prescribing practices.

RECOMMENDATION:
Provide guidance to better prepare prescribers to talk with patients about safety of prescription medications.

Provide clear organizational expectations about safe prescribing practices for patients and families to support prescribing ED physicians and staff in following guidelines.

Explore role of patient advisors to help improve the ED experience of patients not receiving a medication prescription in context of safe prescribing practices.

Explore use of empathic communication development to respond to this population.

Develop qualitative inquiry methods to supplement HCAHPS and other survey results. Better/deeper understanding of the results will help prevent inaccurate conclusions and unproductive incentive/penalty schemes.

Develop a modifier when analyzing survey results to quantify the scope of the issue of a dissatisfied response in context of safe prescribing practices.

Educate senior leaders of inherent conflicts within clinical care, that reside in patient expectation/demand and appropriateness/safety of medications (whether opioids, antibiotics, other).

Alicia Munoz, MAS, FACHE, CPHQ
Vice President, Quality and Patient Safety
Hospital Quality Institute

Julie Morath, MS RN
President and CEO
Hospital Quality Institute

SAVE THE DATE!

Event: 2015 Center for Behavioral Health and EMS/Trauma Joint Symposium*

Location: Mission Inn Hotel & Spa/Riverside Convention Center

December 6	**CBH Board Meeting**
December 7-8	**Joint CBH and EMS/T Workshops/Speakers**
December 9	**EMS/T Committee Meeting**

Event Title and Schedule are still being developed

The Mission Inn Hotel & Spa

3649 Mission Inn Avenue Riverside, CA 92501
(951) 784-0300
missioninn.com

EMS/Trauma Committee Meeting Schedule

2015

WEDNESDAY, MARCH 25, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, JUNE 24, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K STREET, SUITE 800
WEDNESDAY, SEPTEMBER 23, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
SUNDAY, DECEMBER 6, 2015 TBD	Joint Meeting – EMS/Trauma and Center for Behavioral Health Location TBD

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org

Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties